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# Between Ourselves

*A New Year, a new volume number* and, above all, so far as the *Journal* is concerned, ***a new firm to print our magazine.*** Unless we had sent individual letters to each subscriber, there was no way that we could let you know that the printing company that we had engaged to do our work nearly seven years ago had been sold last June. Very probably many of you guessed that there had been some change made when your copies were so late reaching you. We were immediately dissatisfied with the quality of the work the purchasing firm produced. There is only one word that aptly describes the poor workmanship that, by the terms of our contract, we have had to endure for the past six months. It was dreadful!

There are some new developments of which we hope you will all approve now that we are being served by new printers. First, the publication date has been advanced so that your copies will be reaching you earlier. The immediate effect of this change is that, since we have to allow 40 days from the date the first manuscripts go to the printer until the copies are delivered to the post office for transmission to you, we have had to advance the closing date for all material. Articles, reports, new notes, advertisements for positions vacant, etc., must reach us sooner to guarantee their appearance in a specific issue. For example, material in this the January number was all in our hands by November 15. The same pattern of deadlines will be followed for each issue.

The second change is the new type-face in which the articles are set. There was a wide range of styles from which to choose. We believe that you will find this type attractive in appearance and, above all, easy to read.

The other improvements are less prominent. The shifting of page numbers in the Table of Contents to the left-hand margin is one of of them. Can you find the others?

* * *

*There are fewer textbooks* available for reference in neurological and neurosurgical nursing than in almost any other field. That being so, **Dr. John E. Harvey's** excellent description of the work of ***The Nurse in Neurosurgery*** is both timely and worthy of careful study.

Intracranial tumors may develop in any of the structures within the cranium. Thus it is possible to have tumors originating from the meninges, the blood vessels, the nerve cells, and the glandular tissue. They may be either benign or malignant—only after surgery can their true state be determined. The largest number of tumors, by far, arise from the supporting cells of the brain—the glia. Since these gliomas are not encapsulated and thus can spread throughout the brain tissue, their complete removal is problematical. Expert skill is vital. Preceding and following surgery, the reliance placed on the nurse demands that she realize the importance of the care she must give.

* * *

*The article by* **Lois W. Lethbridge** is the first of several that will appear on the Institutional Nursing Page, emanating from an ***institute for nurse-superintendents of rural hospitals*** held in Manitoba last year. It would require more space that we can allocate to publish all of the papers. However, the material was made available to participants at the institute in mimeographed form. It is possible that the entire series may still be procurable from the Manitoba Association of Registered Nurses. Address your inquiries in this respect to *Miss Lillian Pettigrew, 247 Balmoral St., Winnipeg, Man.*

* * *

*We have recently prepared* a more complete ***indexing of the issues from 1930 to 1939.*** So far we have reached no decision regarding the possibility of cutting stencils and making it available for distribution in mimeographed form. It seemed to us that the demand for copies of it would be too limited to justify the time and cost. Perhaps we are wrong in this estimate of its usefulness. Will you write and let us know if many of you would find such a copy helpful for teaching purposes?

* * *

*How many* ***New Year's Resolutions*** did you make? Have you broken them all yet? We hope that one of them that you will keep will be to concentrate some thinking on the questions raised in the **Structure Study** report.

---

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# Not Empty-Handed

IT HAS BEEN said that to get the most from this world one should not enter any one day empty-handed. This is a splendid aim for every member of the Canadian Nurses' Association entering a new year: not to do so empty-handed. This is the only way we can attain our "major objectives—to promote the best interests of the members of the profession and to promote the best interests of the public generally."[1]

How may we make certain we shall not be empty-handed? It seems to me it can only be assured by some straight thinking. It is our duty to learn from those who have gone before us and gain from the store of experience their lives have built up. Some of the older nurses complain that the younger generation pays scant attention to established rules; the younger ones retort that they want to do things their own way. Perhaps both are right. The trick may be for us to think things out for ourselves, using whatever is useful and appropriate from the past to develop the improvements we are imagining. We may find, perhaps in the majority of cases, there is a middle path where both we and those who have different convictions may walk comfortably together.

Let us decide to try a new way—untried ways. "If the Canadian Nurses' Association is to implement its objectives effectively, however, even though in an advisory capacity only, it must do

*Ballard-Jarrett, Toronto*

HELEN G. MCARTHUR

so for its membership as a whole."[1] It is not enough for a few in any organisation to be the doers or the recipients of benefits. The action must involve each member.

We must beware of thinking we have found a short-cut when we accept the opinions of others. We can only profit if we learn to be painstaking in the discovery of the truth for ourselves. Great men are very loath to express opinions on the future. It was Thomas Edison, the inventor, who said, "I haven't any conclusions to give; I am just learning about things myself."

One of the major problems facing every member of the Canadian Nurses' Association is to decide what shall be the future structure of *her* association. For example, the Structure Study Report stresses the necessity for voting delegates at the general meetings to be informed and prepared to vote on questions recommended by the Executive. By inference this has not been too well done in the past: "They must be given the opportunity to learn all the pros and cons of the proposed policies."[1] How can this be accomplished? Do you think the recommendations in the Structure Study will accomplish this? How did you make your decision?

There are two ways to make a decision. We may make observation, weigh the possibilities, and decide what to do or say. Or we can decide without conscious thinking—let our emotions, the thinking of others, prejudices, false values, pigheadedness, step in without any relation to facts. Let us decide to make conscious decisions in 1953. Let us include unwelcome as well as welcome facts; separate important from unimportant; make notes of interesting facts that have a bearing on questions concerning the future of nursing and not only the facts which are interesting to us. If we wish to think effectively, we cannot afford to wear blinkers.

Straight thinking is not easy but it is rewarding. It helps heal our disappointments, cure our indecisions, increase our courage. By pooling the thinking of all Canadian nurses on the problems facing us in 1953, it is my belief that we will make decisions that are sound, are good, and will be in the best interests of the profession and the public we serve. Your national officers cannot make the immediate future fruitful without both the young hands and the experienced hands. We need you all. A good place to start is some straight thinking on the Structure Study of the Canadian Nurses' Association. Share your thinking with your room-mate, your alumnae, your district and provincial association. If you work alone, write your thoughts down and send them in. We need not enter this new year empty-handed. Let us not put off until tomorrow the very thing that may make tomorrow worth living.

"Grant me the serenity to accept things I cannot change; courage to change things I can, and wisdom to know the difference."

HELEN G. MCARTHUR
*President*
*Canadian Nurses' Association*

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1. Jewett, Pauline. A Structure Study of the Canadian Nurses' Association.

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Women, married and unmarried, have to solve the difficult problem of how best they can render public service in the local community, the province, and the nation. Obviously women, being no longer barred by their sex, have a definite obligation to place their time and talents and training at the public service. The problem of the home responsibilities of the married woman is always difficult. It should, however, be remembered that too much of the public service in a local community may be done, and not too well done, by men tired after a long day's work, when it could well be handled, at least in part, by their wives who do, after all, often conduct most of the business of the family. Like the married woman's career, it is a matter for individual adjustment according to particular circumstances. The only general statement that can be made, I think, is that we should all use our common sense and avoid selfishness and laziness—an extremely difficult but very important proceeding.

# The Nurse in Neurosurgery

JOHN E. HARVEY, M.D., PH.D.

WITHOUT GOOD nursing care neurosurgery as practised today would be impossible. The patient who has just been operated upon for the removal of of a brain tumor is to a remarkable degree dependent upon the nurse who is looking after him. It is the surgeon's responsibility to leave complete and explicit instructions for post-operative care; it is the nurse's responsibility to understand and execute these orders, and to use judgment in their application.

Judgment. What is it? Some would say "common sense," and up to a point they would be right. But good judgment requires something more. It requires a background of knowledge; it requires, as far as the nurse is concerned, uncommon sense. The good neurosurgical nurse must be intelligent, alert, and *informed*. It is the purpose of this article to draw attention to the more important problems encountered by the neurosurgical nurse and to provide a modicum of essential information regarding the physiological and pathological background of these problems.

Among the diseases of the brain which the neurosurgeon attempts to control are the following:

1. Brain tumor
2. Intracranial hemorrhage subsequent to a blow on the head.
3. Intracranial hemorrhage due to spontaneous rupture of a blood vessel.
4. Acute paroxysmal facial pain.
5. Epilepsy of certain types.
6. Contaminated wounds of the brain.
7. Abscess of the brain.

## DIAGNOSIS OF BRAIN TUMORS

It is important to appreciate the fact that any one of the symptoms and signs commonly associated with brain tumors *may* be caused by some other disease. With this word of caution the following list of symptoms is presented:

Dr. Harvey is with the Crease Clinic—Research Unit, University of British Columbia, Vancouver.

1. *Headache*—a common symptom: contrary to what one might expect the headache of brain tumors is typically intermittent. The site of the headache is no sure guide to the location of the tumor.

2. *Disturbance of mental functions* ranging from slowing of thought processes to psychosis or unconsciousness.

3. *Paralysis*—usually predominantly or entirely one-sided, on the side opposite to the tumor. May appear early or late in the course of the tumor's growth.

4. *Convulsions*—a generalized convulsion may be the first warning of a tumor's presence. The onset of seizures in a person over 40 is particularly suggestive of tumor and must be investigated with this possibility in mind. Attacks of involuntary movements confined to one extremity may indicate the presence of a tumor affecting the corresponding area of cerbral cortex.

5. *Impairment of vision*—this occurs as a result of either direct damage to the optic pathways, or increased intracranial pressure. If the latter condition is present, relief of the pressure to conserve vision is an urgent matter. A variable degree of visual improvement occurs following operation.

There are many other ways in which a tumor may declare its presence. The foregoing are merely some of the commoner and more obvious ones.

## PATHOLOGY

Brain tumors are much more common that most people think. Of all tumors occurring at all ages they form 2 per cent. About half of these brain tumors are histologically benign—that is, they represent overgrowths of more or less normal cells and they do not, like the malignant tumors, put out tentacles into the adjacent brain. Even these benign growths, however, may be fatal if they affect vital centres or are inaccessible to the surgeon. One common benign tumor is the meningioma; it has a tough fibrous covering and may frequently be removed completely, often with very happy results. To a variety of

malignant tumors the term "glioma" is applied. This term usually connotes a soft tumor which to the inexperienced surgeon may be indistinguishable from the adjacent brain; indeed, the neurosurgeon sometimes requires the pathologist's aid during the operation in order to be quite sure that he is dealing with a glioma. It is worthwhile to remove these malignant tumors if by so doing one can prolong life without crippling the patient. Thus, the location of the tumor within the brain is of great importance.

## Nursing Care

The nursing care of the patient with a brain tumor will be described in some detail, since many of the principles involved are applicable to other neurological problems. The patient may be drowsy. He may for some time have been negligent in matters of personal hygiene. Generally speaking, his nutritional status will be better than that of a patient with, let us say, carcinoma of the stomach. He will seldom be noisy. He may complain of severe headache. This patient, then, requires more than the usual assistance with mouth hygiene, bathing, and elimination. He may require to be fed. Usually he requires no sedation; he may need an analgesic for his headache but he should never be given morphine. Morphine has two very undesirable effects:

1. It depresses respiration.
2. It causes pupillary constriction, thereby masking valuable neurological signs and making it impossible to observe the ocular fundi with an ophthalmoscope.

It occasionally happens that the only record of the patient's condition at the time of admission is that made by the nurse. This admission note is, therefore, particularly important. It should include references to:

1. *Complaints:* Ask the patient in what way he feels ill and summarize his remarks.
2. *General condition:* Usual notes regarding weight, state of nourishment, etc.
3. *The behavior of the patient:* Does he respond rationally and readily to questioning? If he seems drowsy, how readily can he be roused?
4. *Motor activity:* Valuable information is easily obtained. Can the patient walk? Is the gait normal? Have him grip your index finger with the right hand, then with the left as firmly as possible. Is there a difference in the two grips?
5. *Vomiting*, if any.

Pending the writing of specific orders by the doctor, it is advisable to keep the patient in bed. If there is a history of convulsions, bed-rails are necessary. The unconscious patient should be placed in the semiprone position, which will described later.

Vomiting as a consequence of increased intracranial pressure, though frequently discussed in the textbooks, is not quite as common as one might think. Specific measures short of surgery are usually ineffective. In some cases movement or a particular position in bed seems to aggravate the vomiting.

Although the occasional tumor patient may be in a critically ill state, requiring very frequent observation or perhaps immediate surgery, it is more usual for the neurosurgeon to study the patient for a day or more, during which time x-rays of the skull and chest, electroencephalograms and other technical procedures are carried out. Following these relatively simple forms of investigation it is common practice to obtain special x-rays for the purpose of accurately localizing the tumor, immediately after (1) the injection of oxygen into the spaces in and around the brain which are normally filled with cerebrospinal fluid; or (2) the injection of a radiopaque dye into the blood vessels of the brain, so that the pattern of these vessels can be seen on the x-ray film. The picture resulting from the injection of oxygen is called either a ventriculogram (when the oxygen is injected directly into the cerebral ventricles through holes drilled in the skull) or a pneumoencephalogram (when the oxygen is injected into the subarachnoid space in the lumbar region and allowed to rise into the spaces in the brain). The details of these methods are rather complex; however, Fig. 1 to 4 may provide some idea of the principles involved. *Fig. 1* shows the appearance of the x-ray of the skull of a normal person following the injection of oxygen. *Fig. 2* shows

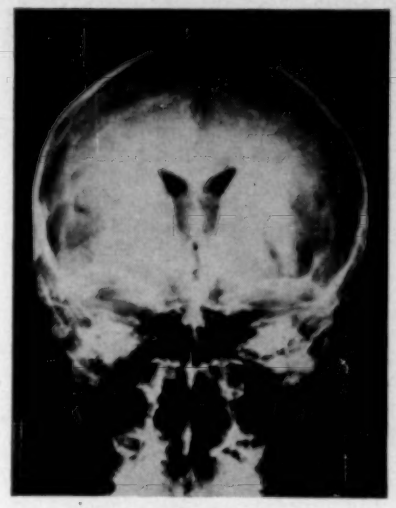

FIG. 1

*Normal pneumoencephalogram.* The symmetrical central shadows are produced by oxygen in the ventricular system which ordinarily is filled with cerebrospinal fluid.

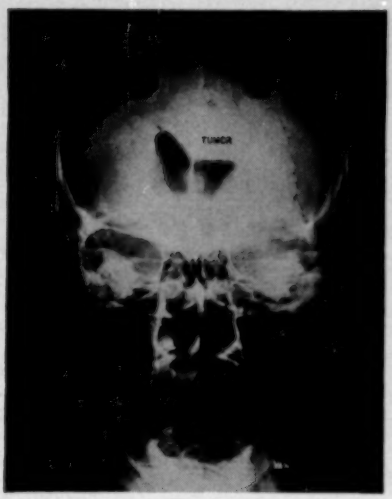


FIG. 2

*Ventriculogram of a patient with a brain tumor.* The ventricles are enlarged and have been pushed away from their normal central position, the top of one of them having been flattened by the pressure of the tumor. The two round shadows are caused by the burr-holes made in the skull for the injection of oxygen.

FIG. 3

*Normal cerebral angiogram—unilateral.* The middle cerebral artery and its branches pass outward and then up. The anterior cerebral artery, shown rather faintly here, passes straight up in the midline.

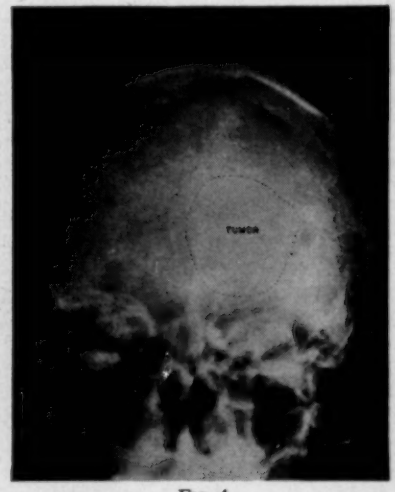


FIG. 4

*Cerebral angiogram of a tumor patient.* Note the displacement of the arteries by the tumor.

how this picture is modified by the pressure of a tumor. By careful studies of such x-rays the neurosurgeon or radiologist can deduce the tumor's exact location and approximate size. Once this information is available, if surgical removal is indicated, it is best done immediately, since the patient's condition may deteriorate rapidly following the injection of oxygen.

A cerebral angiogram is a series of x-ray pictures of the blood vessels of the brain. These vessels do not normally appear in the ordinary x-ray. It is, therefore, necessary to fill them with a radiopaque substance while the x-ray is being made. This substance, called diodrast, is injected into the carotid artery on the side on which an abnormality is expected. Since it goes through the vessels of the brain in about four seconds, the pictures must be taken rapidly. *Fig. 3* shows the appearance of a normal angiogram. *Fig. 4* shows how this normal appearance may be changed by the presence of a tumor.

### Pre-operative Preparation

The preparation of a patient for brain surgery differs in some respects from that preceding other types of surgery. Sedation is commonly ordered, usually in the form of a barbiturate but, as mentioned before, morphine is not used. Most neurosurgeons insist that the head be not shaved until the day of surgery, since little abrasions and cuts are sure to become infected and cannot be adequately sterilized at the time of operation. If a pneumoencephalogram is being done the head will not be prepared until the need for surgery has been proven; for a ventriculogram a partial or complete head prep. may be ordered. In any event, the neurosurgeon or his trained assistant usually does the "finishing touches" of the head prep. with a razor immediately prior to surgery.

### Surgery

The details of skin sterilization and draping vary somewhat, depending on the views of the surgeon performing the operation. As far as the operating room nurse is concerned, the important thing is that she anticipate the surgeon's needs and have ready whatever he considers essential, so that this routine but important part of the operation may be quickly and efficiently carried out.

The actual removal of the tumor, although it is as a rule not an exceedingly complicated procedure, is painstaking and protracted. Certain types of tumor, such as the meningiomas, are apt to require a good deal of time. Complete removal of these is important in order to prevent recurrence. The malignant, infiltrative gliomas can be removed only partially; if the site is a frontal or occipital lobe a lobectomy can be performed very speedily with temporary relief for the patient.

While the surgeon must be familiar with the many details of the structures which he encounters during the operation, the sterile nurse can be expected to follow only the main phases of the procedure; these she must observe and understand as surgery proceeds, for she is an important member of the team. The actual surgery may be divided into five parts:

1. The scalp incision.
2. Turning of the bone flap.
3. Incision of the dura mater.
4. Removal of the tumor.
5. Closure of the wound in layers.

The scalp incision is commonly U-shaped, with the closed portion of the U near the vertex; the reason for this arrangement is that the blood vessels course upward from the base of the cranium. If the surgeon were to cut across them the skin flap might eventually become gangrenous. Since the scalp is exceedingly vascular, absolute control of bleeding is important. This is effected initially by pressure of the fingertips of the surgeon and assistant parallel to the incision, and subsequently by a row of hemostats attached to the inner fibrous layer of the scalp (the galea). Some surgeons prefer to use spring clips which encircle the cut edges and shut off the bleeders without being themselves in the way. Whatever method is used, the instrument nurse must be able to supply the necessary instruments with the greatest speed.

The surgeon next encounters the skull—a rather formidable obstacle. His problem is to remove a portion of it about two or three inches square, the

actual size depending on the location and size of the tumor. First a number of holes—five or six—are drilled through the skull along the periphery of the projected opening. By means of a narrow, flexible saw guide, a flexible wire saw (Gigli saw) is threaded into one hole and out the adjacent one; the saw is then pulled back and forth until it has cut through the bridge of bone. In this manner all the holes are joined up, the loose portion of the skull is then separated from the underlying dura mater and lifted out of the opening.

Most surgeons leave the bone attached to the temporal muscle during the operation but some prefer to remove it entirely and replace it at the end of the operation. If the latter method is employed the nurse has the additional responsibility of keeping the bone in a safe place—above all, off the floor! During the fashioning of the bone flap, and immediately after it has been elevated, the surgeon requires bone wax to press into the bleeding channels in the edge of the bone. This bone wax must be readily available and slightly warm. To control bleeding from the surface of the dura mater a square of cottonoid, moistened with saline or peroxide solution, is applied.

The next step is the opening of the dura mater, to accomplish which a fixed routine is followed. A fine, sharp hook is thrust obliquely through the dura and pulled upon gently so as to draw the dura away from the underlying brain. With a scalpel a 3 mm. incision is made just beside the point of insertion of the hook. A scalpel guide, with the tip bent to the right angle, is then inserted through the incision. A scalpel is used to extend the incision, its point being at all times guarded by the right-angle guide Once the incision is an inch or two long, scissors may be used to complete the opening of the dura.

The details of the removal of the tumor need not be described here. The sterile nurse may be somewhat less busy during this part of the procedure and must, therefore, combat a natural tendency to relax. The danger of sudden, profuse bleeding is always present; consequently gelfoam, silver clips, and tiny sponges must be kept ready for instant use.

Although the details of closure may appear to vary considerably, depending upon the habits of the particular surgeon, the main steps are identical. All oozing of blood from the site of the tumor removal is meticulously controlled. The incision in the dura mater is completely or partially closed. Some surgeons routinely lead a rubber drain out of the space left by the removal of the tumor; others prefer not to do so. The bone flap is fixed in place, usually by means of wire. The scalp incision is sutured rapidly; first the galea is sutured and then the skin itself. If the galeal sutures are well placed, the skin edges will be nicely approximated and bleeding from the incision will have been brought under control. Usually this ideal result is not obtained, however, and the skin sutures are, therefore, desirable to ensure satisfactory closure. The operating team should continue to function at peak efficiency throughout the closure. The fact that this procedure becomes a rigidly stereotyped one cannot be an excuse for unnecessary conversation or the premature removal of instruments. The patient has been through a long operation; more blood is lost during the closure and the prolongation of this procedure exposes the patient to unwarranted risk.

There are many ways of applying a satisfactory head dressing. Provided that the dressing shields the wound from contamination and stays on without being too tight, the details are of little importance.

### Post-operative Nursing Care

At this point begins the post-operative care of the patient—a matter of profound importance. In what position should the patient lie in bed? What sort of observations should be carried out and how frequently should the findings be recorded? How should a marked temperature elevation be dealt with? What dietary restrictions are necessary? How much sedation should be used? The answers to all these questions should be obtainable through study of the surgeon's post-operative orders. If

they are not, the nurse should ask for further instructions. She may properly ask, too, why certain orders are written. Other things being equal, the nurse who understands the basic principles of treatment can do a much better job than one one who follows instructions unquestioningly.

The problem of positioning the post-operative patient can be a difficult one but it can be solved by keeping in mind that deaths in the immediate post-operative period are usually due to:

1. Lack of air.
2. Lack of blood (fundamentally the same condition as (1).
3. Increased intracranial pressure due to hemorrhage or edema.

Lack of air is perhaps the commonest source of trouble and it is the most easily prevented. The bronchi and bronchioles fill up with secretions. Even though these be thoroughly removed by the anesthetist in the operating room they will reappear quickly. If the patient vomits while not fully conscious he may inhale vomitus. There are two answers to this problem—proper position and adequate suction. The semiprone position is most satisfactory. Note that:

1. The bed is *horizontal* throughout.
2. The mouth is turned slightly to the side so as to allow secretions and vomitus to drain freely.
3. The "under" arm is behind the patient, the "over" arm in front.
4. The "under" leg is straight the "over" leg is flexed.
5. The patient is maintained in this position by means of two pillows—one under each free extremity.

The patient should be turned every hour. Every hour, or oftener if necessary a small rubber catheter should be passed through the nostrils to a depth of 8 or 10 inches and withdrawn slowly. At least part of the time it will enter the trachea and remove thick mucus. This procedure is usually carried out too casually and too infrequently. Should breathing continue to be obstructed, postural drainage (with the head a little lower than the feet) or bronchoscopy may be necessary.

The foregoing remarks apply primarily to the unconscious patient. If the patient is waking up at the time the operation is completed, and is having no trouble with breathing, it is desirable to place him in a semi-sitting position for at least six hours. During this early period, intracranial hemorrhage is a danger and the semi-sitting position is useful because it lessens the intracranial blood pressure. If the blood pressure is abnormally low, however, elevation of the head may produce cerebral anemia and unconsciousness. Obviously, nice judgment may be required in order to determine what position is best for a given patient. The frequency of observations is governed by the rate at which the patient's condition changes. At first a half hour may make a big difference and the observations, therefore, begin at half-hourly intervals, becoming less frequent as the patient's condition becomes stabilized. In an uncomplicated case, after the first few post-operative days, blood pressure and temperature need not, as a rule, be taken oftener than q.4 h. Particular attention is paid to the following:

1. The *state of consciousness:* In describing this in her notes the nurse should avoid such terms as "stuporous" "comatose" "semicomatose" etc. It is much better to say "alert, talking sensibly" or "sleeps most of the time, but is easily roused and answers questions well." To one reader "stuporous" means "drowsy"—to another it might mean "deeply unconscious." Simple concrete terminology is desirable.
2. The temperature.
3. The blood pressure.
4. The cardiac rate.
5. The respiratory rate.
6. Variations in the relative size of the pupils.
7. Other changes such as the onset of paralysis of a limb or severe pain.

The nurse making her observations should keep in mind two cardinal principles:

1. Every observation should be recorded.
2. The reason for making each observation should be understood.

The reasons for observing the state of consciousness are too obvious to require comment. In a post-operative brain case a rising blood pressure with a slowing cardiac rate may mean increased intra-

cranial pressure from hemorrhage or edema. The reverse, a falling blood pressure with accelerating cardiac rate, may be an early sign of shock. A rising temperature within a few hours post-operatively usually means that the heat control centre in the brain is temporarily deranged; in such a case, unless the body temperature is kept down by artificial means, the patient may die. A rising temperature later on may indicate an infection of lungs, bladder or (to the surgeon's great chagrin) of the incision. A decreased respiratory rate may result from increased intracranial pressure; an increased rate may indicate pneumonia, an obstructed airway, or a collapsed lobe of the lung. A difference in the size of pupils, which were equal immediately following operation, may indicate local pressure in some part of the brain. A gradually increasing paralysis of a limb may or may not indicate serious intracranial complications. A paralysis of sudden onset often means a post-operative clot in a cerebral vessel. While it is not the nurse's duty to diagnose these complications, it is of the greatest importance that she report the signs which suggest that trouble lies ahead.

Usually the post-operative diet presents no great problem. It should be increased from soft to full diet as rapidly as the patient's condition permits. One restriction must be observed—that of fluid intake. It is usually considered good practice to limit this to about 1,500 cc. daily, or even less, so as to reduce the likelihood of high intracranial pressure from cerebral edema. Fluid intake and output must be accurately measured and charted. With suitable antibiotic therapy, the incontinent patient will usually tolerate an in-lying catheter. Thus the measurement of urinary output is made possible and the highly undesirable situation of a perpetually wet bed is avoided.

Head dressings are changed only by the surgeon or his trained assistant. If a dressing slips off completely or partially the doctor should be notified immediately. The nurse should ask whether a drain has been inserted, since much more soaking of the dressing may be expected if a drain is present. Usually there appears to be more blood on the dressing than is actually the case, because cerebrospinal fluid dilutes the blood. Only by experience can the nurse judge whether the dressing is unduly saturated. It is a safe rule, therefore, to notify the attending physician whenever there is any doubt on this point.

Any patient who has undergone brain surgery may become disoriented and irrational in the post-operative period. Such a patient may do injury to himself by removing dressings, falling or climbing out of bed, etc. Furthermore, he disturbs the other patients even when he is in a separate room. These episodes of restlessness terminate themselves eventually but when present they constitute a problem. As a rule the patient is not receptive to reassurance or admonition; therefore use sedation and restraint.

Sedation must be used cautiously. What has been said about morphine applies in a lesser degree to the common sedatives. Paraldehyde may sometimes be very useful. It is not wise, however, to give enough sedation to post-operative brain cases to depress them to the point of sleep; therefore physical restraint becomes necessary. The mistake is sometimes made of securing one ankle only; if restraint is required it should be adequately used. Leather cuffs and anklets may chafe and for this reason broad strips of adhesive tape are preferred by some. Whatever form of restraint is used, it should be removed at least once in 24 hours and the wrists and ankles examined. Obviously, constriction is to be avoided.

A word should be added about the methods employed to keep the patient's temperature down post-operatively. Details vary. Each surgeon has his own ideas about when alcohol sponging should begin and when simple fanning will suffice. As far as the nurse is concerned, the important thing is to start the cooling procedure on time, as indicated in the orders left by the surgeon. Remember, too, that directing air from an electric fan over a patient has little effect if the patient is covered by pyjamas or a sheet; nor does shivering

indicate that the cooling process should be discontinued.

We have considered some of the important features of the nursing care of the patient with a brain tumor. It may be possible in a future article to extend our discussion so as to include other types of brain surgery.

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# The Everlasting Teamwork . . .

EUGENIE M. STUART

*It ain't the individual*
*Nor the army as a whole*
*But the everlasting teamwork*
*Of every bloomin' soul.*

— RUDYARD KIPLING

THE "NURSING TEAM" which has occupied the headlines of many of our professional journal articles during the past couple of years has become an accepted type of organization for nursing services in our hospitals today. Although we have read with interest of the development of the method and have watched with enthusiasm the demonstration of the technique, still it has been with apprehension that the plan has been put into effect in many of our own nursing units. Now we believe that the nursing team organization is here to stay for it is designed to give every patient the maximum benefit of the combined services of professional and non-professional nursing personnel. This seems to fulfil our part in achieving the purpose for which the hospital exists in the community and for which we exist in the hospital.

But should we stop with the organization and operation of the nursing team? Should we draw imaginary lines around the nursing group and, satisfied with our own effort, settle behind these boundary lines which may limit our perspective and separate us from other members of the hospital staff who are working to achieve these same objectives? Is not the nursing team only a part of another team, a representative hospital team, which is also exerting every effort to give the best possible care to the patient as well as to promote health and prevent illness, advance education, and encourage research? The nursing team may be the answer to the problem of organization and utilization of nursing personnel in the best interests of the patient but in so doing has it taken into account the broad concept of the team?

The Oxford Dictionary states that the word "team" is of Old English origin and was originally applied to "the action of drawing." In 1614 it was "applied to persons drawing together." Definition of the word team is "a number of persons associated in some joint action" and definition of the word "teamwork" is "work done by persons working with concerted efforts." Webster's New International Dictionary defines "teamwork" as.

> The work done by a number of associates, usually each doing a clearly defined portion, but all subordinating personal prominence to the efficiency of the whole.

It is the "whole" upon which we should centre attention for the ultimate objective.

The rapid developments in medical

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science during the past ten years has changed the picture of almost every professional service rendered in the hospital. Concurrent with this changing picture of these professional services has been the constantly changing social and economic picture outside the hospital. This in turn, has had a mighty impact on the business management of the hospital. As a result, the salaried representative of the Board of Directors —the hospital administrator—is faced, on the one hand, with the problem of providing a high, yet economical, standard of professional service to the patient; on the other hand he is expected to administer a highly specialized business organization with a frugal efficiency. This is, indeed, a challenge which requires the wholehearted understanding and efforts of every member of the hospital staff. Consider the complexity of the hospital organization with approximately 163 different categories of employees at all levels, all working with one objective in view—the return of the patient to health and normal living—and you will realize the importance of total teamwork. The total team is made up of the administrator, the physician, the nurse, the physio- and occupational therapist, the dietitian, the medical social service worker, the medical records librarian, the pharmacist, the engineer, the housekeeper, the laundry manager and the office manager, all with the same objective—the restoration of health to the patient.

In some hospitals there is an appreciation of the total organization, of the interdependence of departments, and of the human relationships which should and are built up between various professional groups as well as with those in the lower echelons. But in other hospitals there is only a vague understanding of one or two of the above factors. In many hospitals each department head limits these horizons to his or her own specialty with possible appreciation,but little consideration, for his neighbor.

One may well ask where the responsibility lies for this educational function and without hesitation or question the answer is that this is one of the duties which should be assumed by the administrator in his capacity as a leader. However, there are some hospital administrators who neither recognize nor accept these responsibilities. Under these conditions uncertainty and insecurity, misunderstanding and error, friction and discontent are prevalent and we find an internally competitive organization with a low level of morale.

*Howard Smith, Chicago*

EUGENIE M. STUART

Post-graduate training in hospital administration, nursing service administration, nursing education and other professional fields is focussing attention on consultative supervision. Tomorrow's hospitals should show the results of the mutual understanding between administrator and department head, between department head and department head, and between department head and employee. With the development of leadership qualities at all levels, the groups from the various departments should widen their scope and continue to build ideas of values in to a more effective participation in a democratic institution.

The time is ripe for the expansion of the team concept. With one purpose before us all, let us as a team go forward with a breadth of understanding, a growing appreciation, and a greater capacity to see relationships in the total organization.

# Tuberculosis Among Nurses

R. G. Ferguson, M.D.

In this generation with the steady fall of infection from tuberculosis in all parts of Canada as a result of the rapid decline in the number of deaths from this disease and consequent decrease of spreading foci, the great majority of young girls entering hospitals for training, or sanatoria for employment, at around the age of 20, have not been infected with the tubercle bacillus and have not acquired resistance to tuberculosis. These more susceptible young women, many of whom will, in the natural course of their duties in caring for the sick, be unavoidably exposed to tuberculosis, require protection if they are not to suffer excessively from this disease.

Adequate protection for these employees is the responsibility of all hospitals, if such institutions are to be considered desirable places to work. The solution of the problem reduces the difficulty of maintaining adequate and efficient staff in an era of full employment when young women have increasing choice of employment and health is appreciated as a precious asset.

It must be recognized that nurses caring for the sick are unavoidably exposed to disease. This, however, does not deter them in the least if they are interested in the work and can be assured that protection can be afforded against disease.

## Unavoidable Exposure to Tb.

Where increasing resistance and reduction of infection are major factors of prevention in a program in a community, one problem requiring special consideration is the protection of that group destined to have more than average exposure to tuberculosis infection—those who are known to be to a large degree unavoidably exposed. In order to make the problem definite let us review briefly provisions made for the protection of sanatorium and hospital ward employees.

About two decades ago in many places, particularly in the United States, Canada, Australia, and New Zealand, staff closely associated with bedside care and cleaning in sanatoria and hospitals were breaking down in increasing numbers, as were also nurses in training in general hospitals, and nurses and attendants in mental hospitals. The sanatoria and hospitals became worried over this condition and checked up on predisposing causes of breakdown. Better living conditions, including many new nurses' homes, and the services of dietitians were provided. Better instruction in infectious technique was instituted.

The value of sanitary technique in protection against infection has been demonstrated in both acute infectious hospitals and sanatoria. Considering the human difficulties during the period of apprenticeship, the protection conferred by sanitary habits is in a practical way limited. That is best illustrated by the cases of nurses in training who may be considered amateurs in the practice of sanitary technique. Protection by this method is acquired after long and intensive practice, is maintained at the price of eternal vigilance, and is subject to human error. Notwithstanding these efforts to improve non-specific protection the problem remained. If sanitary technique alone afforded sufficient protection, prophylactic vaccination against smallpox would not be insisted on for nurses nor toxoid prophylaxis against diphtheria in acute infectious hospitals.

In Saskatchewan where, excluding Indians, segregation and treatment had exceeded four patients for each death from tuberculosis for the past ten years. morbidity from this disease had been steadily falling among the general population since 1930. In the sanatoria and hospital employees, morbidity had not fallen. New active cases of tuberculosis discovered (1930-38) in Saskatchewan are shown in the accompanying figures.

For many years prior to his retirement, Dr. Ferguson was director of the program of tuberculosis control in Saskatchewan.

## TUBERCULOSIS AMONG NURSES

| *Year* | *Graduate Nurses* | *Student Nurses* | *Assistant Nurses* | *Total* |
|---|---|---|---|---|
| 1930 | 12 | 10 | 2 | 24 |
| 1931 | 10 | 14 | 2 | 26 |
| 1932 | 10 | 12 | 0 | 22 |
| 1933 | 12 | 9 | 2 | 23 |
| 1934 | 7 | 10 | 0 | 17 |
| 1935 | 10 | 7 | 0 | 17 |
| 1936 | 10 | 10 | 3 | 23 |
| 1937 | 5 | 10 | 5 | 20 |
| 1938 | 12 | 11 | 8 | 31 |
| | — | — | — | — |
| *Total* | 88 | 93 | 22 | 203 |

On June 30, 1939, there were under treatment in Saskatchewan: 17 graduate nurses; 13 nurses in training; and 12 other hospital attendants—constituting 5.3% of the 780 patients under treatment.

This study shows that during the period of 1930-35, the average incidence of admissions among nurses in training was 1.14% per annum, and for the years 1936-38 inclusive, 1.6% per annum. The average for the nine-year period (1930-38) was 1.44% per annum. This incidence was nearly ten times that found among young adult Normal School pupils examined each year in a similar age group (0.15%) and nearly ten times that in the general female population in Saskatchewan in the age group 20 to 24 years known to have fallen sick in 1938 (0.152%).

In 1930 a further effort was made to protect the staff against serious disease and a routine examination by x-ray on employment was established, followed by periodic x-ray examination. Still a high morbidity persisted. In 1934 tuberculin testing on employment and of negative reactors at intervals thereafter was established. In 1939 it became possible to make a preliminary analysis of the information gained by a study of tuberculin, x-ray and physical condition in three sanatoria. This study revealed three outstanding facts:

It was found that in the interval an increasing proportion of the staff employed, year by year, had negative tuberculin reactions, the proportion increasing from 31.7% in 1934 to 60.4% in 1938.

It was found that unavoidably exposed staff with negative tuberculins soon became positive. Of those groups having more or less constant contact with patients, 60 per cent became positive within the first year of service with very few going beyond two years.

It was observed that a higher proportion of the breakdowns occurred among employed persons with a negative tuberculin reaction, compared with the incidence among those employed with a positive reaction. Among 359 exposed persons having a positive tuberculin on employment during the five-year period from January, 1934, to December 31, 1938, 1.1% developed lesions demonstrable by x-ray, an incidence of 0.22% per year. This incidence, although slightly higher than that suggested by admissions for treatment from young adults in the age group 20-24 years in the general public (0.152) in the same province, was very much lower than that found among young adults on the same staff negative to tuberculin on employment.

During the same period, among 306 employees found negative to tuberculin on employment, 2.026% per annum developed lesions demonstrable by x-ray. Not all of those who developed lesions required treatment. Small lesions cleared up while continuing work under observation. You may feel that these transitory lesions were of no practical importance. Nevertheless, after eliminating lesions which did not require treatment among those 306 persons, 1.04% per annum required sanatorium treatment. This incidence was 4.7 times greater than the number requiring treatment among those employed with a positive reaction.

It would appear from these observations that favorable living and working conditions in hospitals and sanatoria, combined with preventive technique as practised, gave reasonable protection to

persons who had acquired the resistance afforded by previous infection without a parenchymatous lung lesion, but that these conditions did not provide adequate protection for negative-to-tuberculin employees in the same environment. Sanitary technique, if perfect, would eliminate infection but, inasmuch as it is subject to human error, it may be at least expected to avoid infection in some cases and to reduce infections in others. It protects some of the fortunate and very painstaking but in most cases merely postpones the evil day when accident or laxity will let down the bars for infection.

In September, 1938, it was decided to offer prophylactic vaccination with B.C.G. to all negative-to-tuberculin nurses in the eight large general hospitals in Saskatchewan and to all negative-to-tuberculin employees in the three sanatoria of the Saskatchewan Anti-Tuberculosis League.

In the period from July, 1945, to June, 1950, the employees of the League have been protected by sickness and accident disability insurance, including tuberculosis, with standard individual policies at minimum standard rates. The experience of the insurance company has been satisfactory.

The serious situation that had been developing with regard to excessive incidence of tuberculosis among nurses and sanatoria employees who did not react to tuberculin on entering the environment, during the period 1930 to 1938, has not been present since vaccination of negative reactors was begun in September, 1938. The nursing schools and the League in Saskatchewan no longer have anxiety and worry with regard to excessive tuberculosis developing among the negatively reacting staff.

Since this study was made vaccination has been introduced in many large hospitals and most sanatoria from British Columbia to Newfoundland and, wherever practised, the results have been to eliminate excessive tuberculosis among negative-to-tuberculin nurses.

**Comparative Experience in the Period 1934 to 1947 Inclusive**

(Including any cases developed since leaving hospitals up to November, 1948)

| Hospital Nurses in Training | *No. Persons* | *Tb. Cases* | *%Tb.* |
|---|---|---|---|
| Total vaccinated observed... | 2,223 | 18 | 0.809% |
| Total negatives not vaccinated... | 1,368 | 55 | 4.02% |
| Ratio of cases in vaccinated to negatives not vaccinated 0.809%: 4.02% = 1:4.97 | | | |
| **Saskatchewan Sanatoria** | | | |
| Total vaccinated..... | 1,223 | 21 | 1.8% |
| Total negatives not vaccinated... | 247 | 32 | 11.67% |
| Ratio of cases in vaccinated... to negatives not vaccinated: 1.8%:11.67% = 1:6.6 | | | |

It will be seen from the accompanying table that vaccination of negatives reduced the incidence of tuberculosis cases in the hospital group to its fifth and in the sanatoria group to its sixth.

## How to be Popular

Do you want to be popular—or more popular than you are? There is no easier or surer way than this: Make it a point to remember the nice things you have heard said of anyone you know and repeat them to him or her. No matter how big or important the man or woman, a genuine compliment always gives pleasure. You like to hear pleasant things about yourself. Why not confer that pleasure on others by repeating the compliments you hear concerning them? This world needs more pleasant reports and fewer biting criticisms. Life has hard roads a-plenty and discouragements not a few. If you can make sad experiences less painful by saying or repeating a kind word, why not do it? How much better that would be than to repeat only the disagreeable things one hears! —*Selected*

# Our New Operating Room

DOROTHY MONTEITH

ON AUGUST 28, 1951, we moved into our new building—the Guelph General Hospital. Because of the improved lay-out and modern equipment of each department, it required revision of nursing procedures and many adjustments for each individual. Although much thought and planning was necessary before moving, we made many changes after working in the actual situation.

The control of wound infection in the operating room depends not only on the structural design and the quality of equipment but on the conscientious and intelligent use of this equipment by all personnel. We have attempted to standardize equipment and material to meet the needs of this hospital and to ensure individual technique for each patient.

Standardization of packs and the preparation of basin sets is an important step in this regard. Instead of preparing a pack for Dr. Jones or Dr. Smith, they are prepared as abdominal, perineal, minor, or ear, nose and throat. The contents and the manner in which the articles are folded and arranged allows for 30 minutes' exposure to saturated steam at 250°F. The sterility of these packs has been thoroughly checked by the use of a Lag thermometer and the 30-minute period has been found to be adequate. The surgeons' special requests are packaged separately as necessary. We find this method is more efficient and convenient.

The basin sets are wrapped in such a manner that when the bundle is placed in the basin ring the wrapper itself is the sterile drape.

All large bundles are tied with heavy cord and in such a way that the cord can be removed quickly and re-used. Small packages are tied with string. Every article for sterilization is marked with indelible pencil on a small printed sheet of paper as to contents, date of sterilization, and the initials of the person who prepared the package. This has proved a satisfactory check method. Errors in packaging can be corrected immediately. The date on the outside of the package ensures that no article is left too long in the cupboard and thus helps to eliminate re-sterilizing.

Our operating room suite consists of an interchange area, instrument and sterile storage room, doctor's record desk, supervisor's office, recovery room, five operating theatres, and two sub-sterilizing rooms. The interchange area provides a change room for all personnel, access for those who deliver laundry and all other necessary supplies, and space for the patient's bed while surgery is in progress. An entrance from the main corridor to the surgeons' dressing room has made it possible to enforce the rule that all must change before entering the operating room. Not only is this an important factor in surgical technique but it eliminates some of the possible hazards arising from static electricity.

Since the patients now come to the operating room in their own beds, it was necessary to make a change in the procedure for making an anesthetic bed. The patient is transferred in the interchange area to a stretcher and then to the operating table. It is the responsibility of the operating room staff to make the anesthetic bed. The foundation of the bed is made in the usual manner, then the top bedclothes are fan-folded to the bottom of the bed. The flannelette blanket has been eliminated from the bottom and instead one is placed in the blanket warmer.

When the operation is finished the bed is wheeled into the operating theatre, the patient is transferred directly to the bed and covered with this flannelette sheet. The patient is then taken to the recovery room. The reasons for this procedure are:

1. It prevents unnecessary moving of bed linen in the operating room.
2. It is helpful in the prevention of immediate post-operative shock.

Miss Monteith is operating room supervisor at the General Hospital, Guelph, Ont.

3. The thoroughly heated flannelette sheet provides more warmth to the patient than the usual two hot-water bottles placed in an anesthetic bed and also eliminates the danger of burns.

Patients remain in the recovery room until they are conscious, their blood pressure has stabilized, and they can be safely returned to the ward. Not only has each individual patient benefitted by this treatment but many hours of nursing care have been saved for other necessary duties on the wards.

The sub-sterilizing room consists of four scrub sinks on the outside wall, a high speed instrument sterilizer, an instrument washer sterilizer, a utility sink and cupboards, flush rim hopper, Fenwall solution, blanket warmer, and a mop closet. The planning of this room has eliminated unnecessary traffic from the operating room. As a general rule the actual sterile field is taken for granted by the surgeons but with the opportunity to see the sterilization of instruments, etc., a greater interest has been aroused.

Fenwall flasks with a special pour-lip are used for sterile solutions such as water, normal saline, etc. The large 2,000-cc. flask is practical for hand-basins. It has been no problem to provide sufficient sterile water by this method. This is a much better technique than is possible with water tanks and water pitchers, the dangers of which are obvious.

Great emphasis is placed on the cleanliness of the floor. A solution of sodium hypochlorite, as a disinfecting detergent, is used to scrub the floors after each operation. The cleanliness of the mop itself is an important factor. This is an easy task when it is cleaned in the flush rim hopper and stored in the mop closet.

Each operating room is furnished with an operating table, an overhead and auxiliary light, anesthetic table, infusion stand, three single-basin rings, instrument tables, adjustable stools, footstools and a small metal hamper for holding wrappers and string from sterile packages.

Sterile supplies, such as textiles, scalpel blades, sutures, transfer forceps, etc., and parts for the operating table are stored in a built-in cupboard with four glass shelves and sliding glass doors. This provides adequate space to store supplies for a 48-hour period. A printed chart, illustrating number and placement of articles, is kept in each wall cupboard. New personnel, especially student nurses, find this reference chart most helpful in locating required articles.

It has always been a problem to keep anesthetics, equipment for administering them, and all parts of an anesthetic machine in a convenient place for the anesthetist. As a result, we designed an anesthetic table of sufficient size to allow for two six-inch drawers and one eight-inch drawer. The top drawer is divided into three sections. From the right side of the table, a metal shelf pulls out which is large enough to hold the patient's chart. The table is constructed of stainless steel and perichrome finish which facilitates cleaning. This has provided adequate space for syringes, needles, Pentothal sets, intratracheal tubes, and all other necessary articles. A reference chart is also kept in this table.

With the exception of the high-speed instrument sterilizer and instrument-washer sterilizers, the sterilizing unit and its usual workroom space was eliminated from the operating room suite. This means that all sterilizing, except instruments, is done in the Central Supply Room. This also means that all utensils, syringes, needles, etc., can be taken to the Central Supply for the final cleaning and wrapping. Our problem was to figure out how we could best deal with soiled linen and utensils immediately following the cases.

The answer was found in the designing of an instrument table to serve two purposes: to be used for the sterile instrument set-up and then to be used for a quick but efficient clean-up at the end of the operation.

We chose a standard 48-inch table to which we added two drawers and a special frame with hinges at each end of the table capable of holding a draw-string laundry bag. A definite number of laundry bags are kept in each drawer. Before the sterile instrument table is prepared a laundry bag is placed in each frame but the frame itself is left parallel to the legs of the table. At the end of the

operation the frame is raised, providing for the disposal of linen in one laundry bag and all utensils in the other.

In addition to this the circulating nurse brings the bucket for the instruments and a large waterproof paper bag from the adjoining sub-sterilizing room. The instruments, suction tubing, suture needles, etc., are carefully placed in the bucket ready for the instrument washer. All gauze sponges and any other articles for the incinerator are discarded into the paper bag.

We feel this method of clean-up is most effective because it is not time-consuming and, above all, it keeps articles used during the operation in one place until the scrub nurse has dealt with each in the proper manner, thus preventing the possible spread of bacteria whether the case had been classed as septic or not.

Terminal sterilization following septic cases is most essential. A specially designed cart is brought to the operating room providing all the necessary items for cleaning the contaminated field. This procedure is very similar to the one mentioned above excepting that we use aqueous zephiran 1:1,000 for cleaning the furniture. Use of the room is possible in from 15 to 20 minutes.

Our efforts to improve aseptic technique would not have been possible had it not been for the confidence and understanding of the administrator and the director of nurses, the full cooperation of the surgeons and Central Supply staff and, primarily, the work and enthusiasm of the operating room staff.

# Rural Sanitation

LAUREL E. BENHAM, C.S.I. (C)

NURSES POSTED to outlying areas not covered by provincial or county health units very often find themselves confronted with many requests to aid with sanitation problems. To comply with these requests, it is most important to know what facilities are available to solve the various difficulties. In keeping with this thought, let us discuss the following items: milk control; control of water supplies; construction of privies and septic tanks.

## MILK CONTROL

Always stress the fact that milk that has not been pasteurized is a potential health hazard. Cows, like humans, are subject to diseases, some of which are contagious to humans. Milk handlers can also infect the milk with certain contagious diseases. To pasteurize at home, put a pan of milk on the stove, bring it just to the boil, remove it quickly before the scum forms over the surface, cooling it down to 50°F. as quickly as possible, then store it in a cool and protected place.

If a dairyman selling raw milk, or one of his customers, wishes his supply checked, write to the Division of Laboratories of your department of health and ask for their assistance. If they do not supply ice-packed shipping cases, you could arrange to have one made locally. This case is insulated on all sides, top and bottom, has a metal ice container which sits in the centre of the box, so that the milk bottles can be arranged around it. If the ice container is large enough (three quarts) milk can be kept cool in transit up to 24 hours and shipped by any mode of transportation. The laboratory service in each province is free, although the transportation charges would likely have to be paid by the dairyman requesting the sampling. As to interpretation of results, you may request an explanation from the laboratory or read up on the subject from available books obtainable from the

Mr. Benham is sanitary inspector with the North Okanagan Health Unit with his headquarters in Vernon, B.C.

library of your provincial department of health. Two books, in particular, supplying this information are:

1. Municipal and Rural Sanitation by Ehlers and Steele. Third Edition.
2. Rural Health Practice. Mustard.

Keep in mind that allowable maximums regarding bacterial count may differ from one province to another. Be sure to inquire from the laboratory what the allowable is. There is one maximum for raw milk and a lesser one for pasteurized, although it is unlikely that you would be testing anything but raw milk in your remote area. Unless you can obtain samples in the original bottles supplied by the dairyman, you will have to sterilize sample containers or obtain them from your provincial laboratory.

As your area will no doubt be comprised of unorganized territory, you will have no authority of legislation to force any changes on local dairymen. Your role will be that of an educative, consultive service.

If you are unable to ship out samples, particularly because of transportation problems, endeavor to secure either a methylene blue or a reductase test kit from the provincial laboratory if they will provide it, or by purchase if you are referred to a commercial source. This is a very easy method of determining whether the milk is satisfactory or poor. Request instructions for proper use of the kit when you order it.

### Control of Water Supplies

Most of the water supplies for farm or individual residences are derived from wells and springs. For safety these must be protected from surface washings and from pollution by the hands or feet of persons and from the entrance of animals.

The location of the well and its proximity to any possible contaminating source is all-important. A well should not be dug in a hollow where it is bound to collect all the surface drainage. The well should not be closer than 100 feet to any privy, chicken house or barn, and should never be downgrade from any of these. If it is economically impossible for a family to cement crib and top the well, the space between the plank crib and the dirt sides should be filled with gravel and tamped. The plank cribbing should be built up a bit above ground, so that clay soil can be piled around it, then tamped on a slope so that surface water or drip from the pump spout will flow away from the well. The well-top should be covered with tin or sheet metal, which extends down the sides partway, to prevent drip back into the well.

The rope-over-pulley-to-pail type of well should be constructed the same as above, except that the top of the well should be waist-high for convenience in handling the pail and should be made as tight as possible under the circumstances. Poultry should be excluded from any well area but particularly from this type. A large revolving wooden axle suspended over the well and rotated by a handle is an easy method of raising and lowering the pail. This method also prevents the rope from coiling on the ground when the bucket is being raised.

People using spring water should fence off the spring, sink a watertight box or barrel to trap the bubbling water, and provide the box or barrel with an overflow spout. This spout prevents the malpractice of dipping into the spring water. It should flow into a watertight trough to lead the overflow away from the spring. If possible, the earth should be heaped up around the box or barrel and tamped, to prevent surface drainage from the upgrade running down into the spring. This type of water supply is clearly illustrated on page 92 of the book mentioned above by Ehlers and Steele.

With regard to water sampling, sterile sample containers can be obtained in most provinces from the Division of Laboratories of your provincial department of health. Sample containers include instructions on how to take a sample and how to interpret the results of the test.

If a well is obviously open to contamination, it should be stressed that, regardless of the test result, serious contamination could occur at any time. Therefore, the well should be reconstructed along safer lines or perhaps replaced by one in a safer spot. It is usually people who have dug a new well, or who have just moved on to a farm, who

want a sample taken. If they are insistent, and more than just your advice is needed to persuade them to properly reconstruct their well, then take a sample for them. It will usually confirm your suspicions.

If a sample report shows possible contamination, the well can be chlorinated before reconstruction and again sampled to see if the suspected source of contamination has been eliminated. To chlorinate, put a one-pound package of chloride of lime, obtainable at any grocery store, into a pail. Stir while adding water until a thick paste is formed. Then fill the pail up with water, violently agitating the paste. Let this mixture sit all day until the sediment has settled to the bottom. Skim the surface particles off, then pour the solution into the well; being careful to keep any of the settled sediment from running into the well. The next day, pump or bail out water until the taste of the chlorine has disappeared. Sample again, to see if the contamination is eliminated. If it has the job should now be completed by reconstructing the well to preclude the possibility of any further contamination.

### Privies and Septic Tanks

An important fact to remember in connection with privies is that, if properly constructed, they are not unsanitary. The following points should be observed in their construction:

1. The privy base should be considerably larger than the pit it covers.
2. The base should be banked with tamped clay to prevent surface drainage filling the pit, particularly in the spring.
3. The floor of the privy and the seat riser should be absolutely fly tight.
4. The privy holes should be covered with hinged lids, which can be made self-closing by nailing a wooden block on the rear wall, so that they must be held open.
5. As this construction tends to make the pit more or less airtight, a box vent should be provided, screened at its outlet.
6. During the summer months, the pit should be dosed every few days with either chloride of lime or slaked lime.
7. If these instructions have been carried out, the construction of the upper part of the toilet need serve no other purpose than ensuring privacy and protection against the elements.

If it is desired that a privy be kept in a permanent location, pails can be substituted in place of a pit, and the seat riser made to lift up so that the pails can be removed for burying the night soil.

With regard to septic tank construction, point out the following:

1. The best lifetime tank is a cement one.
2. The inlet and outlet to the tank should be either vitrified or cast iron T-pipes, or a substitute wooden chute.
3. Although recommended sizes vary, for an ordinary household of two to five people, a septic tank should be 4′ x 7′ inside measurement.
4. The effluent from a properly working septic tank still constitutes a potential health hazard, and should be controlled by running it into a tile field laid not more than 18″ below ground level, or into a leaching pit. Although the length of tile field varies with the type of soil, as a guide an ordinary house should utilize about 65 to 75 feet of tile in sandy or gravel soil. If soil is hard clay or hardpan, the length of necessary tile must be greatly increased and the ditches in which the tile is to be laid must be filled with gravel, below and above the tile. Do not use any of the clay or hardpan to finish filling the tile ditch, as it will prevent evaporation which must take place.

The information concerning the above noted subjects can be rounded out by perusing the textbooks mentioned or any others which no doubt could be obtained from your provincial department of health library.

The various sources of information which could be made available to you are as follows:

1. Department of National Health and Welfare—Public Health Engineering Division.
2. Your provincial department of health —Sanitary Engineering Division.
3. Your provincial department of health —Division of Laboratories.
4. Canadian Public Health Association, 150 College St., Toronto 5, Ont.
5. Canadian Institute of Sanitary Inspectors, 150 College St., Toronto 5, Ont.

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It costs more to revenge injuries than to bear them.—Thomas Wilson

# Lyle Creelman *Writes* . . .

THOSE OF YOU who have had the good fortune to visit Finland know what a wonderful experienced that is. I spent two delightful weeks last August attending, for most of that time, a seminar on Social Casework at Keurusselka. This summer Holiday Hotel is in the lake country of Finland, about five hours by train north of Helsinki. The lakes and the beautiful forests of pine and birch reminded me so much of parts of our own land. The countryside is dotted with neat red houses all with white trimmings. Those who wonder about the small wooden building situated not far from every house, and probably near a lake, and from which smoke may be issuing, will soon learn that it is a *sauna* or Finnish bath. Last year, for the Olympics, the Finnish Government printed some attractive booklets about Finland. One is entitled "Sauna—The Finnish Bath" and it explains that "the little wooden hut in the trees by the lake is even more important and essential to a Finn than a bathroom, with hot and cold water laid on, is to the inhabitants of other countries."

The simplest form of family sauna is a one-room hut built of logs, with a rudimentary furnace, over which stones are piled, in one corner. Steps lead up to a slatted wooden platform along one side of the room, where naked bathers sit or lie in the hot air under the roof. The stones are heated until they become red-hot. Water is thrown on them to produce steam in a temperature which may be as high as 280° F. The ideal temperature is between 190° and 200° F. The air remains dry because the heat is absorbed by the wooden walls of the bathing room. The temperature in the Finnish bath is considerably higher than in the Turkish bath, because the body can stand far more dry than damp heat.

After perspiration, there follows beating with leafy birch branches, washing, and a plunge in the nearby lake, or a roll in the snow outside the hut. Then a spell of rest while the body cools down completely.

By tradition, Saturday is sauna day. Early during the day the furnace is stoked and lit and, towards evening, after a week of heavy work, the Finn goes to his sauna to cleanse and refresh himself. He does not think of it merely as a means of getting clean. He goes to the sauna for mental relaxation and enjoyment. Because the sauna gives him enjoyment, he wishes to share it with others. He invites guests to his sauna just as he invites them to meals.

The sauna is part of the life of the Finn, as necessary, he feels, as food and drink. From it he draws health in good days and to it he looks for a remedy when he is ill. It is so necessary that when a Finnish countryman starts to build a new home he builds the sauna first and afterwards the house.

Every visitor to Finland invariably tells about the sauna before describing the professional aspects of the visit.

Sixty-four social workers from 15 European countries attended the seminar. It was organized by the United Nations in order to provide an opportunity to discuss the casework approach and how it might be introduced into European social work agencies. This method seems somewhat new to Europe and can only be developed gradually with careful adaptation to the European scene. One of the three faculty leaders was Miss Marjorie Smith, director of the School of Social Work at the University of British Columbia. She told us how casework actually originated in Europe with Vives, a Spaniard, who worked in Belgium around 1525, and by others who followed him and developed it further. In spite of the seeming contradiction, it is really not something new being imported from America.

During two brief days in Helsinki I met many of the nurses who have studied and visited in Canada. At the College of Nursing they were just preparing to take in a new class. You may have heard that during the Olympics the building which houses the college was used for the visiting women athletes—some 580 from 47 countries. Kitchen facilities were provided so that the various national foods could be prepared. You may be interested to know that the College of Nursing was built prior to 1939 to house a group for the Olympics that were scheduled for 1940 in Finland. A very effective way of ob-

taining such a lovely building for nursing!

At the college they were continually experimenting in their basic nursing course. They have always included public health throughout the whole curriculum and for the last six months of the three-year course those who wished to specialize in this field could do so. They are making a change this year, however, and at least a year's experience is going to be required of every nurse before she can take a specialty.

Another interesting development in Finland is that nursing preparation will probably, in the future, be basic for midwives. In other words, midwifery will be a specialty based on nursing.

To discuss public health nursing with Tynne Luoma is, indeed, a stimulating experience. I am sure many of you know that Finland has for some time had a law that requires that there shall be one public health nurse for every 4,000 population and one midwife for every 5,000. They have achieved this and now they are aiming at one public health nurse for every 3,000. The advances made in public health nursing in Finland during the recent years have been remarkable. They have, in the whole country, 723 health centres. Of these, 461 are "Health Houses," all of which have been built since 1944. The "Health House" is a building which houses not only the health centre, where the various clinics are held, but also has living quarters for the public health nurse and midwife. Along with them there is frequently a "Home Help"—a person trained to help in the home when the mother is ill or is absent. In addition to the main health centres there are nearly 3,000 sub-centres where regular clinics are also held. So the whole of Finland is very well covered as far as public health nursing activities are concerned.

There are problems, too. One of the greatest for the nurses is transportation. Out of nearly 1,000 public health nurses only about four have cars. The most common method of transportation is by bicycle. In the winter, of course, skis are used. Salaries are very low according to Canadian standards. Normally a public health nurse would receive about 30,000 Finnish marks per month. This is equivallent to a little less than $100. Out of this the unmarried nurse has to pay an income tax amounting to nearly one-third of her total income.

The cost of living is high. I paid more for a hotel room there than in any other continental city. Those who know the Finnish people, know how much they love coffee. One morning I stopped at a restaurant for a mid-morning cup. After enjoying it thoroughly, I looked at the bill, it amounted to 160 marks or nearly 70 cents!

Helsinki has been called "The White City." Certainly when you drive through its beautiful streets you can understand why it has received this name. There is a very great housing shortage. Some 23,000 people in Helsinki alone are without adequate accommodation. Many new apartment blocks are in the process of being built. It is interesting that ample space, with tall pines and birch trees, is being left between the new buildings.

If you have an opportunity to visit Finland—don't miss it! The undaunted courage of the people and the professional outlook in nursing will give you a new lease on life.

## Anesthesia For Cardiacs

The cardiac patient is vulnerable to surgical procedures involving strong sedation and general anesthesia, particularly if the latter is required for more than a short period of time. Study of pentothal, the most commonly used "short-acting" intravenous anesthetic, has shown that the drug has the serious disadvantages of progressive localization in the fat of the body and a slow rate of inactivation. Administration of anesthesia for a long period results in accumulation of a large amount of pentothal in the body, which produces a post-anesthetic depression of excessive duration. This has led to the study of a number of new compounds derived from or related to barbituric acid and one that appears to have suitable characteristics is under clinical trial.

*—U. S. Public Health Service*

# Nursing Profiles

**Rhoda Ferguson MacDonald** has embarked on an interesting new piece of work—the development of a program as the first school of nursing adviser for the province of Nova Scotia. She was a very happy choice for this task as there are few nurses who have a more varied knowledge of the needs of schools of nursing. Her background of experience should prove beneficial to all the personnel she will have occasion to meet during the experimental stages of this program.

A Cape Breton Islander by birth, Miss MacDonald taught school for a couple of years before she entered the school of nursing of the Glace Bay General Hospital for her training. In one way or another she has been teaching and advising almost constantly since she graduated in 1928.

Private nursing and general staff work at Sydney Mines Hospital for a year preceded her return to her alma mater as assistant superintendent. At her own request, so that she might learn the problems of the night supervisor, she filled this position for three years. Then she became day supervisor of the various departments, in turn, at the Glace Bay hospital, assisting also in the teaching department. In 1937 she enrolled in the course in teaching and administration in schools of nursing at the University of Toronto.

Miss MacDonald returned to Glace Bay and served as superintendent of the hospital for three years. Teaching called to her and she responded by spending one year at Moncton Hospital followed by five years at the city Hospital in Sydney. For two years she was director of nurses and nursing education at Aberdeen Hospital, New Glasgow, N.S., then for the past three years at Payzant Memorial Hospital, Windsor, N.S., she was administrator and director of nursing.

RHODA F. MACDONALD

The professional side of nursing has not been neglected by this capable leader. She has served in various positions, including the presidency, with the Registered Nurses' Association of Nova Scotia, has been active in the hospital association and has kept up her interest in the work of her alumnae.

**Alice Ruby Maria Major** is a lecturer in courses relating to teaching and supervision at the McGill School for Graduate Nurses. Born in Saskatchewan, of Swedish-English parentage, Miss Major graduated from St. Boniface (Man.) Hospital in 1939. Following a brief period of private nursing and staff work, she enlisted with the nursing service of the Royal Canadian Air Force. Upon her release from service in 1945, she enrolled in the McGill School, securing her Bachelor of Nursing degree two years later. She received her Master of Arts at Teachers College, Columbia University, the following year.

Miss Major turned to neurological nursing as her specialty and, prior to her present appointment, was instructor at the Montreal Neurological Institute. She was also lecturer for a time in the school of nursing at Boston University.

One of the most prominent personalities in Canadian nursing, **Elinor Mathilde Palliser,** retired last October after serving as principal of the school of nursing and director of nursing service at the Vancouver General Hospital since April, 1943. A graduate in 1921 of the school of nursing of Johns Hopkins Hospital, Baltimore, Miss Palliser secured her certificate in teaching and supervision in schools of nursing at the McGill School for Graduate Nurses, returning there several years later to qualify in administration in schools of nursing. Her earlier professional experience included eight years as instructor at Wellesley Hospital, Toronto, and nearly five years as assistant superintendent of the Guelph General Hospital.

To her work at V.G.H., Miss Palliser

ELINOR M. PALLISER

brought, in addition to her professional preparation, a fine sense of humor, tolerance, understanding, and the ability to bring out the best in her associates. Her persistence, in the face of seemingly insurmountable hindrances, roused the public to an appreciation of the necessity for a new nurses' residence that today is outstanding. She firmly believed in the maxim that "a happy nurse means a satisfied patient." Every possible means of ensuring the successful adjustment of her students to their new life was taken. Miss Palliser's personal interest in each young woman who entered her school has meant much to the hundreds of nurses who have graduated under her direction.

Miss Palliser has moved to eastern Canada to be near to the members of her own family.

*Bridgman's, Vancouver*

HELEN M. KING

**Helen Margaret King** has established a new precedent by becoming the first graduate of the Vancouver General Hospital to be appointed as the director of the school of nursing there. For the past seven years Miss King has been the assistant director.

Born in Middlesex, England, where she received her early education, Miss King enrolled in the school of nursing of the Vancouver General Hospital in 1924. After graduation she joined the staff there, later working at the Tranquille Sanatorium and in the hospital at Williams Lake, B.C. She secured her certificate in teaching and supervision from the McGill School for Graduate Nurses in 1943, returning to V.G.H. as clinical instructor in the obstetrical department.

MARY MASON

**Mary Mason** has been appointed assistant director of Volunteer Nursing Service, Ontario Division, Canadian Red Cross Society. Born and educated in Toronto, Miss Mason is a graduate of Toronto General Hospital. She secured her certificate in public health nursing from the University of Toronto. Following graduation she worked in the Outpost Service of the Red Cross until her enlistment with the R.C.A.M.C. in World War II. Soon after returning from overseas Miss Mason joined the Indian Health Services and worked in Alberta and Ontario. This breadth of experience will be of great value to her in the new role she has undertaken.

**Adelaide McKnight** has retired after 30 years of service, most of it as supervisor of treatment rooms at the Muskoka Hospital, Gravenhurst, Ont. A party was held in her honor by the hospital staff when she was presented with a set of silver toilet articles.

# In Memoriam

The death at The Montreal General Hospital, on October 16, 1952, of **Jennie Webster, O.B.E.**, at the age of 88, marked the end of a long career of service to humanity. Born in Grafton, Ont., in 1863, Miss Webster graduated from The Montreal General Hospital in 1895. From 1900 until 1933 she held the position of night superintendent of the hospital, gaining the confidence and respect of all who were privileged to work with and learn from her.

Dr. B. F. Johnston, superintendent of the Central Division of The Montreal General Hospital, said of Miss Webster, "Her devotion, her sense of justice, her unfailing concern for the patients' needs and her delightful sense of humor have endeared her to thousands—patients, staff, and general public. In her passing we have lost something very dear."

*Courtesy, Alumnae Association*
*The Montreal General Hospital*

JENNIE WEBSTER

**E. Augusta Ariss,** who graduated in 1895 from the General Hospital, Guelph, Ont., died in California early last year. During her professional life Miss Ariss helped to establish several hospitals in Montana and acted as superintendent of one of them for 30 years. Since her retirement in 1932, she had lived in California.

* * *

**Margaret Cameron Brown** died in Victoria early in October, 1952, at the age of 84. A graduate of the Nanaimo General Hospital, B.C., Miss Brown had worked in hospitals throughout British Columbia and for the past 20 years had been on the staff of the Aged Women's Home in Victoria.

* * *

**Sara Agnes Carey** died on October 14, 1952, at St. Vincent de Paul Hospital, Brockville, Ont., after a long illness. A graduate of St. Joseph's Hospital, Chicago, she was a well known member of the nursing profession and had resided in Brockville for several years.

* * *

**Agnes Cox,** who graduated from Victoria General Hospital, Halifax in 1907, died in Vancouver last September. Miss Cox retired from her duties in the Halifax Tuberculosis Hospital in 1947 after 25 years' association with the work there. Previously, she had worked in Alberta and Nova Scotia hospitals, had engaged in private nursing, and had been on the staff of the Victorian Order of Nurses.

* * *

**Theresa E. Gerry,** who graduated from McKellar Hospital, Fort William, in 1918, died in that city on October 10, 1952. She had become well known through serving for 17 years as city public health nurse, retiring because of ill-health in 1937. Active and interested in community welfare, she was a valued member of many organizations.

## IN MEMORIAM

**Jennie Isabel (Walker) Gilbert** who graduated from the Hospital for Sick Children, Toronto, with the class of 1931 died on October 8, 1952, in London, Ont., at the age of 44. Mrs Gilbert had lived in Toronto and Stratford before going to London.

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**Elizabeth C. Giffen,** a retired nurse, died in August, 1952, in Brampton, Ont.

* * *

**A. E. Gilroy,** a graduate of the 1898 class of the Winnipeg General Hospital, and first president of the W.G.H. nurses' alumnae, died in the hospital on October 14, 1952. Miss Gilroy had done private nursing at the Children's Hospital, Winnipeg, and social work with the Kindergarten Settlement Association.

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**Cleo Audrey McCrea,** age 21, a 1952 graduate of the Hotel Dieu Hospital, Kingston, Ont., died in Kingston on October 11, 1952, as a result of a serious motor accident.

* * *

**Christine (Malcouronne) McLaughlin,** a graduate of the class of 1941 of the Queen Elizabeth Hospital, Montreal, died at Queen Mary Veterans' Hospital, Montreal, in April, 1952. She had served as a nursing sister in World War II with No. 13 and 22 C.G.H. in Newfoundland and overseas.

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**Vetti (McCabe) Rutherford,** who graduated in 1941 from St. Eugene Hospital, Cranbrook, B.C., died in October, 1952 at Ocean Falls, B.C., from bulbar poliomyelitis.

* * *

**Catherine (McKinley) Winder,** who graduated from Sarnia General Hospital, Ont., in 1932, died after a long illness in April, 1952.

## In the Good Old Days

(*The Canadian Nurse*— JANUARY 1913)

"I CANNOT HELP thinking that the patients in the wards of our hospitals are sometimes subjected to what one might call 'rush treatment.' It must be so where one pair of hands is expected to do so much work in a given time. Of course we know that to many of the patients in the public wards it all seems most palatial. But that is surely no reason why the staff should not be large enough to dispense that royal treatment without the fearful rush which seems to be the common method in the institutions of today."

* * *

"An ice pick can be improvised by fixing a cork in a thimble then running the eye part of a stout darning needle into the cork."

* * *

"It has been found that the secretions of the nose are the source of infection of poliomyelitis. Professor Rosenau stated that he had discovered that the disease was conveyed by the bite of the stable fly. It is believed that general acceptance of these views will result, in the near future, in those suffering from the disease being strictly isolated."

* * *

"To prevent the bite of insects take one ounce of epsom salts and dissolve it in one pint of water. Wet the body all over with this solution. Do not wipe the skin. I am very certain that flies, gnats, fleas, bed-bugs or mosquitoes will never touch persons so treated."

* * *

"The cost of printing *The Canadian Nurse* is going up. Each issue costs $200 to print." (In 1952, the cost was approximately 10 times as great!)

* * *

"Milk stations are cheaper than hospitals and will save the lives of more babies. Why not put the baby before the best window in the house and, if necessary, put the geraniums in the closed and darkened rooms? Throw soothing syrup to the fishes. It may be hard on the fish but it at least will save the baby from harm."

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No man is really happy or safe without a hobby, and it makes precious little difference what the outside interest may be—botany, beetles or butterflies, roses, tulips or irises; fishing, mountaineering or antiquities—anything will do so long as he straddles a hobby and rides it hard.

— SIR WILLIAM OSLER

*Institutional Nursing*

# Nurse Superintendent of a Community Hospital

LOIS W. LETHBRIDGE

IT IS NOT MY intention to discuss with you the various functions you may have assumed in the performance of your job, largely because your real function lacked careful delineation, but rather to discuss the position for which you were primarily employed—administrator of the nursing service of your hospital. Taking a realistic view of conditions as they exist today, we see that, while large hospitals have the services of an administrator or business manager, a director of nursing services, pharmacist, purchasing agent, dietitian, medical records librarian, accountant, admitting office staff, housekeeper, etc., the smaller community hospitals combine these departments and the individual entrusted with the responsibility of directing all of them is called the *nurse superintendent*.

## ADMINISTRATOR

What should be the qualities of a successful nurse superintendent? Most authorities seem to be agreed that she should have executive ability, tact, kindness, firmness, courage, the ability to cooperate with hospital staffs (doctors, nurses, and other employees) as well as the public. Characteristics such as tolerance, understanding and, above all, a sense of humor must be developed. I may add that the patience of Job, the wisdom of Solomon, and the disposition of a Saint are also helpful.

It is the duty of the board of governors to appoint the nurse superintendent and to clearly outline to her the duties she is expected to perform. At the direction of the board, the superintendent carries out the policies governing the institution. May I place particular emphasis on the fact that it is *the responsibility of the board* to define all the policies governing the institution. These policies are the principles and rules of action that guide the hospital to its objective. The superintendent, acting for the board, must direct the activities of the hospital in conformity with these policies. The responsibility of the superintendent is to point out to the board policies which need definition.

It is a matter of utmost importance that the superintendent should attend the meetings of the board. On this subject I quote from an address given by Mr. A. J. Swanson, superintendent of the Toronto Western Hospital:

> Strange as it may seem, it is a fact that in some hospitals the superintendent does not attend the board meetings. I do not see how these hospitals can function efficiently, as the superintendent is the liaison between all departments of the hospital and the board of governors. She should be there to report and explain any item in connection with the various departments which might come up at the board meeting. For that reason it should be a laid-down rule that the superintendent attend all board meetings. She cannot be familiar with the reason for certain policies which might be enunciated by the board unless she sits in on the discussion and contributes that suggestions she can from her own experience. In the well run hospital there must be the utmost co-operation between the governing body and the superintendent.

What is hospital administration? It is common sense interpretation and ap-

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Before Miss Lethbridge assumed her present duties as assistant executive secretary with the Manitoba Association of Registered Nurses she was nurse superintendent of the hospital in Portage la Prairie, Man.

plication of general policies laid down for us by our governing boards. The real superintendent is appreciative of honest effort and she expresses that appreciation judiciously. We all crave approval and appreciation. The real superintendent shares the sorrows of her staff and contributes to their happiness. She tries to know her staff individually. Faithfulness, loyalty, and efficiency are not commodities to be purchased by the highest bidder; they are matters of morale—and morale is an emotional attitude to be striven for. The real superintendent strives unceasingly to appreciate the viewpoint of her fellow workers, the patients, and the public. If she goes on duty every morning with a smile and displays friendly interest in everyone she meets, isn't it logical that her attitude may be reflected in the care the patient receives? If, on the other hand, she walks into the hospital disgruntled and belligerent, it is almost certain that she will find trouble immediately.

When we are consulted by a department head or an employee it is often convenient to say, "Well, that will have to wait. I'm busy right now." Thus we create a state of confusion and, by so doing, foster the inefficient performance of duty we are all seeking to prevent. If we can't solve a problem immediately, we certainly owe it to the interrogator at least to explain why and to give some idea when a decision or a subsequent interview may be expected. "Passing the buck" has no place in hospital administration or personnel training. If matters requiring attention are allowed to accumulate on our desk and our department heads are forced to wait indefinitely for routine decisions, we are setting an example of inefficiency that will affect the entire organization. The habit of completing work as it appears is an excellent example to set for our employees.

Good administration requires constant vigilance. It is by no means an eight-hour duty, especially in the smaller hospitals. The nurse superintendent cannot attend to the smooth and efficient management of the institution from her office desk. Frequent rounds and unexpected visits to departments can be of untold help towards sound administration and management.

To assist her in the performance of her job the nurse superintendent must be a student. This does not necessarily entail formal courses of study. It does mean that she will carefully peruse the many excellent hospital magazines, nursing journals and manuals, published monthly, and that she will attend and participate in the annual and regional meetings of hospital workers.

*The Hospital Nursing Service Manual*, published by the American Hospital Association and National League for Nursing, states that the functions of a director of nursing should include:

1. Organizing, directing, and supervising the nursing service, both day and night, in order to ensure sufficient and competent nursing care for patients.
2. Carrying on a continuous analysis and evaluation of the nursing service rendered.
3. Selecting and recommending for appointment the members of the nursing personnel, defining their respective duties, and establishing the general pattern of delegated authority and responsibility.
4. Selecting and recommending for appointment the auxiliary nursing personnel, defining their duties and coordinating their activities.
5. Securing the physical facilities, equipment, and supplies which are required in carrying on the nursing services.
6. Initiating and conducting problem-solving conferences of nursing service personnel.
7. Cooperating in the establishment of personnel policies which will assure reasonable hours and other acceptable working conditions, adequate remuneration, and security of tenure and which will provide for the intangible values which motivate personnel to do their best work.
8. Administering the personnel practices under the policies established by the governing body.
9. Arranging for attractive and healthful housing and living conditions for the resident members of the staff.
10. Providing for health service and care in illness for the nursing service personnel in accordance with the stated policy of the hospital.
11. Arranging for and participating in programs of in-service education, including the orientation of new members of the staff.

12. Encouraging and facilitating the professional advancement of the members of the nursing service personnel.

13. Arranging for the in-service training of auxiliary personnel.

14. Maintaining a record system which indicates the qualifications, experience, and accomplishment of each member of the nursing service personnel.

15. Promoting and maintaining harmonious and effective working relationships with physicians, and the various departments of the hospital and volunteer groups and any agencies with which they are affiliated.

16. Maintaining cordial relationships with patients, their families and their friends, and interested groups in the community.

17. Interpreting the aims of the nursing department to the community through reports, participation in community meetings, and community contacts.

"Nurse superintendents in small hospitals are required to administer without the assistance of personnel directors or training directors and we can devote only a small portion of our time to training. However, if we call together our staff nurses or supervisors for one hour once a week, if possible, but certainly once a month and discuss with them common problems and the interpretation of policies, which amounts to a discussion of the administration of the hospital, the results will more than outweigh the time spent." Giving our supervisors and nurses a share of the glory that goes with policy interpretation will result in their enthusiastic endorsement of the policy when it is placed into effect. Conferences with auxiliary personnel should be held quarterly. By no means should the superintendent do all of the talking. She should bear in mind that it is not a disciplinary meeting but a friendly get-together during which each staff member can present her difficulties.

It is the responsibility of the superintendent to see that a nursing procedure book or manual is maintained on each ward. The nursing procedure book is a mimeographed or printed manual containing outlines for all procedures carried out by the nurse, according to the accepted method of the hospital.

### Nursing Care

Nursing care in the community hospital of today is usually performed by professional nurses, nursing assistants, and aides or maids. It is the responsibility of the nurse superintendent to see that each patient receives the amount and kind of care that his condition requires.

When a hospital admits a patient and accepts the responsibility for his treatment it enters into an implied contract to furnish adequate care. Included in this arrangement, and one of its most important aspects, is the quantity and quality of nursing service rendered the patient.

An analysis of the patient's total nursing needs is the responsibility of professional nurses. Such an analysis will indicate whether a professional nurse should give all care, or whether she should be assisted by a practical nurse or nursing aide, or whether the character of his nursing needs makes it safe for his care to be assumed by the auxiliary worker under the supervision of the professional nurse.

### Admitting Office

The admitting office is the key position in any hospital. Since first impressions, on patients and their relatives and friends, are lasting, the personnel for this department should be chosen carefully. Often, after hours, it will be run by the nurse superintendent herself. Whatever the system is for admitting patients, tact, courtesy and kindness are essential. The task should be made pleasant for the patient and unnecessary delays avoided.

On arrival, the patient should be treated as a guest, every effort being made to gain his confidence and to make him feel at home in his new surroundings. If relatives accompany the patient, they should be kindly received and not made to feel they are a nuisance. This often requires much patience on our part. The required statistical and financial information should be obtained on admission and for this task, which is often an ordeal for the patient, privacy should be provided. No person wishes to discuss such matters over a counter or in a crowd. Every courtesy and consideration should be shown to patients when they are entering and leaving the hospital as this is one of our best opportunities for developing good public relations.

### Medical Records

It is not one of the duties of the nurse superintendent to police the medical staff for the data necessary to complete the required medical and clinical record. Policies governing the maintenance of medical records should be very clearly outlined by the board, perhaps through a liaison committee of the board and medical staff. The nurse superintendent should attend the meetings of this committee as an ex officio member.

### Responsibility for Patients' Property

The nurse superintendent is responsible for enforcing the policies laid down for the care and protection of the patients' property.

While a hospital is not an insurer against every possible source of danger to a patient, it is bound to use all such reasonable precautions as human judgment and safety are capable of. If this duty is not performed the hospital is liable.

This law applies wherever there is a contract, by force of which a hospital is to furnish for a patient's comfort the services of its employees. Where the injury to the patient is caused by the act of the hospital's employees, done in the course of their employment, the hospital is liable for their negligence or for the violation of this contract between the hospital and the patient.

### Public Relations

The importance of a hospital's public relations is well recognized. "The most productive means the hospital has for creating and maintaining good community relations are to render a high quality of professional service and to establish kindly, sympathetic and understanding relationships with its patients, their relatives and their friends. Attaining both of these results depends upon the competence and spirit of its personnel. No group within the hospital is in a more favorable position to create good public relations than is the personnel of the department of nursing."

### Dietary Service

It is a fact that the reputation of the hospital in the community often rests upon the quantity and quality of the dietary service. In a small hospital, the purchasing of foodstuffs and the planning of the menu, if not the actual preparation, will be one of the duties of the nurse superintendent. The most economic method of accomplishing our aim—satisfied patients, personnel, and kitchen staff—lies in the preparation of a master menu. What is a master menu? Briefly, it is a menu, based upon Canada's Food Rules, which in its original form can be served to all staff and ambulatory patients but which can be modified for special, light, soft and liquid diets.

### Hospital Aids

One of the more pleasant duties of the nurse superintendent is the opportunity to work in close cooperation with the Hospital Ladies Aid. We are indeed shortsighted as hospital administrators if we do not make full use of the abilities of this group of women. May I urge you not to accept as yours, duties such as mending, preserving, etc., duties which prevent you from accomplishing your real job—good administration. If these and related problems are put before the members of the aid, a solution will be found immediately. "As ambassadors of understanding and good will between the hospital and the community which it serves, this body can render an invaluable service."

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It has been found that many deaths of infants have resulted not, as was once thought, from mechanical suffocation, through bedclothes covering the child's face, but through unsuspected respiratory diseases. Any symptom of respiratory trouble in a baby should have immediate medical attention.

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It has been demonstrated that the thyroid gland has a controlling influence on the synthesis of protein. Studies have indicated that rats whose thyroids have been removed have responded to force-feeding by increased accumulations of fat but not by bone growth or protein deposition.

*Public Health Nursing*

# Suppose Tommy Won't Eat

MRS. G. T. HAIG, M. SC.

THE DEVELOPMENT of the science of nutrition together with publicity, has brought with it increased feeding problems. You may well ask how that can be—one would think that the more you know about what foods are best for us, the fewer problems we would have. It has come about because parents are so conscious of what Tommy should eat, that they have not considered the possibility he may not like the foods offered. They are so anxious that he eat up all his vegetable, that they want to stuff it down his troat, ignoring his own wishes.

This results in an upset child and a mother who is anxious and cross. If the scene is repeated at every meal, it soon becomes a battleground of tenseness and struggle. You know what happens to your own appetite at the dinner table if there is a disturbing quarrel—your stomach churns, your nerves are taut, and you don't feel like another mouthful. That is what happens to Tommy when he is emotionally upset. He loses his appetite.

That brings us to the crux of the situation. Mother's object when feeding Tommy is to let him go on thinking of food as something *he* wants. "The aim is not to make the child eat but to let his natural appetite come to the surface so that he will want to eat." DR. B. SPOCK.

When do feeding problems begin? They can start at any time actually but most often occur when the baby is beginning to become a young boy or girl. Between the ages of one and two years the child's rate of growth slows down and, therefore,he needs less food. A rule of thumb tells us the baby increases his birth weight three times in about a year, four times by the time he is two years. The second year, as compared with the first, is, therefore, a much slower process of development. Mothers do not think of this when Tommy suddenly refuses a favorite vegetable or cuts down on his milk. There are other reasons, too, why Tommy is not eating as much. Perhaps he is getting a cold and has a sore throat or maybe is just overtired. Whatever the reason he knows how much food he needs. At such times it is natural for him to want to eat less. The feeding problem begins when mother insists he take "just ten bites more"!

Dr. Clara M. Davis, pediatrician, did some revealing research with regard to the self-feeding of babies and small children. In one experiment she took several eight-month-old infants and allowed them to choose their own food. They were confronted with a tray of bowls containing a variety of simple, wholesome foods. The attendants were entirely passive, helping the babies to eat only after they had indicated a preference. They were allowed to go on "food jags"—that is, three or four servings of one food at a time if they so desired. Dr. Davis found that, over a considerable length of time, the babies chose adequate diets. Each separate meal was not well balanced but if the baby avoided one type of food for a while, he eventually returned to it so that he never suffered from a deficiency. It was interesting to note that from meal to meal, and from day to day, the appetite varied greatly. The babies developed normally and were in good health compared to similar infants whose food was chosen for them.

These experiments allow us to draw certain conclusions. A child's appetite

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is an excellent guide, both to the food he needs and the quantity required. This is true, of course, provided he is offered a reasonable variety of *wholesome* foods, as outlined in Canada's Food Rules. Incidentally, Dr. Davis' work has sometimes been misinterpreted to mean that a child can be depended upon to select his food under ordinary circumstances. It must be remembered that the infants with whom she worked were fed under carefully controlled conditions and, furthermore, had not had an opportunity to form likes and dislikes. However, her work illustrates that infants have a far greater capacity for self-regulation than is usually recognized.

Mother can, therefore, safely satisfy Tommy's preferences by changing one food for another i.e., an extra serving of fruit for a vegetable or by changing the form in which the food is served i.e., milk in cream soup instead of as a beverage. It means that the mother should know something of food values in order that she may feel confident about substitutions and changes. Parents may feel that to do this is to spoil the child but experience has shown that Tommy will eventually have fewer dislikes if given some leeway. Dr. Davis' work points out that babies vary in their dislikes and if these are humored the child will accept the food another time. Forcing him to take a "temporary dislike" may mean a "permanent hate."

One's attitude toward food and mealtime is therefore important. If the mother is to avoid emotional tension her attitude should be casual and friendly. She should not force the child. This includes using the more subtle forms of force such as urging, pleading, bribery, trickery or threats. Incidentally when you say "force" a mother may take this literally and will say most emphatically that she *never* forces the child to eat—meaning she doesn't hold Tommy's nose and pour the food down his throat! Pressure, such as pleading or bribes, again creates an emotional situation that may help for a while but that soon brings bigger problems. In my work with mothers at child health centres I have found that some mothers, who were careful to avoid saying anything that could be construed as urging Tommy to eat, were creating a disagreeable attitude by their facial expressions or by their actions. A frowning or glowering parent may not speak a syllable but it is easy to sense her disapproval.

A common expression used with children is "Eat up your meat and then you can have your dessert." Let us stop to analyze this statement. You put a premium on the value of the dessert and at the same time imply that meat is a food you must eat even if it doesn't taste good. It also leads Tommy to feel that *mother* wants him to eat the meat, while *he* would doubtless prefer the dessert. If Tommy prefers dessert at the start of the meal then give it to him. If it is all wholesome food it doesn't matter in what order he eats it. Another expression which would be better forgotten is "but cereal is so good for you"! Tommy soon becomes prejudiced regarding anything that is "good" for him before he has even tasted the food.

Some mothers may feel they have a feeding problem with their children when they really haven't. I'll never forget one mother with whom I chatted one day. She was terribly worried about her two-year-old because she was "hardly eating a thing"! The child was making a satisfactory gain in height and weight and seemed to have lots of pep. I casually inquired as to the exact amounts and kind of food she was eating. She had a substantial breakfast of about 4 ounces of orange juice, ½ cup oatmeal, an egg, a piece of whole-wheat toast, and 6-8 ounces of milk. Her lunch and dinner were comparable in quality and size and yet this mother was terribly worried when her little girl wouldn't eat more. Her problem was her own ignorance of how much food a small child needs.

Developing good food habits in children means setting a good example. Children are born mimics and they love to copy their parents. Lots of fathers have surprised themselves into learning to like a particular food in an effort to show Junior how everyone eats it. If it is impossible to re-educate father, at least keep him quiet about how he hates turnips. Avoid conversation about what

foods you do or do not like as Tommy soon learns to say he doesn't like peaches, not because he really doesn't, but rather because he wants to be like everyone else. I know one mother who illustrates this beautifully when she says, "But Tony doesn't *like* tomatoes"! By saying this in such a manner she gives Tony a sense of importance. He becomes a "man of distinction" for not liking tomatoes and, of course, he'll never try to like them.

Parents should avoid comparing how much a child eats with how much the boy next door eats. Children develop at their own rate: their progress is best judged individually. Youngsters of the same size eat different amounts of food although they may grow at a similar rate.

Parents who definitely have a feeding problem with their child need a lot of encouragement to persuade them to to continue carrying out the recommendations. Much of the worker's time is spent reassuring parents that eventually Tommy's appetite will improve if they are patient. After the initial interview they rush home relieved to have received some help and anxious to put words into action. This very enhusiasm for doing the right thing is probably what led to the feeding problem in the first place. At a second conference, about a week later, they usually are most downhearted. The most effective reply is to say that habits (good or bad) take time to form and improving the poor ones may take even longer. This satisfies the parents and renews their purpose.

As soon as a child is old enough to feed himself, and perhaps even before then he responds to the general attractiveness of the food set before him and the environment around him. The same rules we use for making meals attractive for adults apply to children's meals. Color is important. Tommy may not be fussy about plain custard but when it is colored green he is delighted. Too much or too bright a color may have adverse effects. I heard of one small fellow who suddenly refused all meals but did drink his milk. It turned out he disliked the new ruby glass plate which, to him, changed his food. His mother wisely switched to the old plate and all was well. My own small son refuses milk from a silver mug but drinks thirstily from a fruit-juice glass. This again illustrates that small children have minds of their own and a mother is wise not to make an issue of such things.

Research has shown that small children dislike foods that are stringy or gummy; they prefer simple dishes instead of mixtures; lukewarm temperatures rather than very hot or extremely cold foods. In introducing a new food it is best to give it in a small quantity, perhaps with some other food that Tommy especially favors.

Dawdling is a common complaint about older children in the preschool period. It happens because the child is intensely curious and has such an avid interest in everything around him. After his first hunger pangs are satisfied he may be distracted by other things—an older child, a blaring radio, etc. Therefore it is wise to avoid distractions at mealtime as much as possible. Give Tommy 25-30 minutes in which to eat, then quietly remove his plate. He will soon learn to satisfy his hunger within that period provided he is not filling up on snacks between meals.

I have referred to Tommy as if he were a very small child. This is because it is the time when habits are formed and, therefore, of utmost importance. With the school-age child, one can stimulate interest in food by allowing him to go marketing for the family or by letting him add the odd item to mother's list. If Tommy plants his own carrots in the garden he will likely be enthusiastic about eating them. Children enjoy learning to cook and serve the meals—even preparing a simple meal by themselves. Such encouragement by parents influences food habits and good eating.

In conclusion, it is important to let Tommy decide how much food he needs and to allow him some leeway regarding likes and dislikes. In this way he will take most foods that are offered with little fuss. It is obvious that in order to instil good food habits, it is essential that Tommy have a well balanced program of exercise, fresh air, and rest. They are necessary if the food he eats is to be of full benefit to him.

*Aux Infirmières Canadiennes-Françaises*

# Tétralogie de Fallot

DENISE LABRECHE *et* PIERRETTE BOISCLAIR

C'EST L'HISTOIRE d'un petit garçon de huit ans que nous verrons aujourd'hui. Raoul est le sixième d'une famille de huit enfants habitant un taudis de trois pièces. Ses frères et soeurs jouissent tous d'une santé relativement bonne.

Né de parents pauvres et peu soucieux de leurs responsabilités, il fut plutôt laissé à lui-même. Le père, un alcoolique invétéré, et la mère d'une nature indifférente, ne font qu'assurer à leur enfant la subsistance, se désintéressant complètement de son éducation. Ils remarquent bien que l'enfant est plus débile que les autres, qu'il est facilement dyspnéique et cyanosé, qu'il contracte souvent des rhumes mais ils ne font rien pour améliorer cet état.

Le petit Raoul, ainsi rejeté de son milieu familial, grandit plutôt sauvagement. Son développement intellectuel semble celui d'un déficient mental et son état physique l'empêche de fréquenter l'école.

C'est dans cet état misérable que le découvre une agence de service social. On le confie aussitôt, par l'intermédiaire de l'Assistance Publique, à l'Institut Lavoisier, centre de physiologie cardio-pulmonaire situé à Montréal. D'après les rapports de cet institut, l'enfant, à son arrivée, est très agité, instable et ne semble pas très bien comprendre ce qu'on lui dit. Il parle peu et sa prononciation est mauvaise. La moindre effort provoque une cyanose intense. Le coeur bat à un rythme régulier de 110. La tension artérielle, de 80/40, ne peut être entendue qu'au bras gauche. Le médecin note, à l'auscultation du coeur, des bruits anormaux parmi lesquels un souffle systolique de tonalité aiguë dont le maximum d'intensité s'entend au foyer pulmonaire. L'enfant ne peut demeurer en décubitus dorsal: il semble mal à l'aise et devient plus cyanosé. Les analyses faites en vue de découvrir des signes de maladie pulmonaire se démontrent toutes négatives. On soupçonne alors une malformation congénitale et on décide de confier l'enfant à des spécialistes en cardiologie de l'Hôpital Notre-Dame.

Pendant les quelques mois passés à l'Institut Lavoisier, Raoul qui possède toutes ses facultés mentales mais dont le développement seul était retardé, apprit à vivre en société. Bientôt, avec les soins attentifs du personnel tout entier (Raoul est le seul enfant de l'Institut) il devint affable et son langage s'améliora.

Raoul fut amené à notre service pédiatrique au mois de janvier, 1952. A son arrivée, sa température est de 99.2° F., sa pulsation de 80, et sa respiration de 20 à la minute. On fait aussi le dosage des liquides ingérés et excrétés pendant 24 heures. Résultat: 1,500 cc. pour les ingestats et 620 cc. pour les excrétats. Ce dosage fut continué par la suite mais donna toujours une ingestion plus grande que l'excrétion. La transition de l'Institut Lavoisier à notre hôpital fut un peu difficile pour l'enfant qui dut s'adapter à un milieu nouveau et bien différent de celui qu'il venait de quitter. Parfois, il pleure et pousse même des cris.

Le repos complet au lit est nécessité par son état. D'autre part, les contrariétés augmentent ses troubles respiratoires et circulatoires. Le problème fut de concilier les deux points. Avec beaucoup de patience et de douceur, en faisant appel à sa gentillesse, on parvint cependant à le confiner à sa chambre et à lui faire accepter les différentes prescriptions médicales car l'enfant a mainte-

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nant une compréhension normale bien qu'il soit un peu difficile.

D'après les symptômes présentés par le malade et les analyses et tests qu'on lui fit subir, les cardiologues confirmèrent bien vite le diagnostic fort soupçonné de "tétralogie de Fallot." Le dictionnaire nous dit que "la tétralogie de Fallot est un affection congénitale rare, caractérisée par l'association d'un rétrécissement de l'artère pulmonaire et d'une communication interventriculaire qui amène un mélange de sang veineux avec le sang artériel et, secondairement, par l'hypertrophie du ventricule droit et la déviation de l'aorte vers la droite."

Le sang, au lieu de passer du ventricule droit aux poumons par l'artère pulmonaire pour revenir ensuite par les veines pulmonaires dans l'oreillette gauche et, de là, arriver au ventricule gauche, passe partiellement mais directement du ventricule droit au ventricule gauche. Une partie du sang, ainsi, ne bénéficie pas de l'hématose qui se fait au niveau des alvéoles pulmonaires.

Voici les tests et analyses faites dans le but de confirmer le diagnostic:

*Angiocardiographie:* C'est un cliché du coeur que l'on prend à la suite d'une injection I.V. de diodrast, substance à base d'iode. Cette dernière, en la colorant, permet de suivre le trajet de la circulation. Comme résultat, on constata la communication interventriculaire avec une extra position de l'aorte placée à cheval sur les deux ventricules. Pour confirmer ce résultat, on injecta alors 1/10 de cc. d'éther par voie I.V. Normallement, cette substance est immédiatement éliminée par les poumons. A cause des troubles circulatoires, il se produisit ici un prurit intense de quelques secondes dû à l'élimination incomplète de l'éther.

*Electrocardiogramme:* A l'aide d'un électrocardiographe, on peut, par ce procédé, enregistrer un graphique des contractions cardiaques. Cet examen confirma une hypertrophie du ventricule droit.

*Orthodiagramme:* C'est un procédé qui permet de déterminer les dimensions du coeur d'après son image radioscopique. Comme résultat, on note un léger débord droit. Dynamique normal. Sinus costo-diaphragmatiques clairs.

*Analyses du sang:*

Azotémie (urée)—Résultat normal.

Glycémie—Un peu au-dessous de normal. La circulation anormale ne semble pas avoir entravé les processus métaboliques.

| Formule sanguine: | | Normale |
|---|---|---|
| Glob. rouges: | 6,500,000/4,500,000 | à 5,000,000. |
| Glob. blancs: | 13,000 / 6,000 | à 9,000. |
| Hémoglobine: | 129% / 90 | à 100%. |

Les globules rouges sont augmentés pour compenser l'apport insuffisant d'oxygène fixé par le sang qui se rend aux poumons. Les globules blancs, en plus grand nombre, permettent à l'organisme de se défendre contre les produits toxiques non entièrement éliminés. A cause du passage du sang veineux dans le sang artériel, on note aussi une augmentation de l'hémoglobine.

| | | |
|---|---|---|
| Hématocrite: | 61% | 42 à 49% |

Par un procédé de centrifuge, on peut séparer les globules du plasma. L'évaluation de la masse globulaire permet de constater l'hémoconcentration. Cette dernière se comprend assez facilement dans le cas qui nous intéresse.

| | | |
|---|---|---|
| Sédimentation: | 1 mm. | 1 à 12 mm. |

Dans une éprouvette graduée contenant un anticoagulant, on dépose environ 5 cc. de sang. A des périodes déterminées, on note la ligne de séparation entre la partie solide et la partie liquide du sang. Le graphique qui en résulte au bout d'une heure démontre la vitesse de sédimentation. Il existe un rapport entre la sédimentation sanguine et certains phénomènes internes de défense. La sédimentation exagérée indique un processus d'inflammation ou de destruction cellulaire dans l'organisme.

*Analyse d'urine* se démontre tout à fait normale: la couleur est jaune; l'apparence limpide; l'odeur sui generis, et la densité 1.019.

La tétralogie de Fallot est une affection qui ne se traite que chirurgicalement. Au bout d'environ deux semaines, le diagnostic étant confirmé, on décida de l'opération. Notre petit malade fut alors conduit au service de chirurgie thoracique.

Au début, ce nouveau déplacement agite l'enfant. Il est instable et refuse de faire ce qu'on lui demande. Mais, peu à peu, devant la douceur de ses infirmières, il devient moins craintif. On s'efforce de ne pas le contredire et bientôt c'est avec docilité qu'il accepte médicaments et traitements.

La préparation à cette grave opération implique en premier lieu un repos physique complet. Cette mesure est requise en vue d'éviter toute activité qui ne fait qu'augmenter sa dyspnée et sa cyanose. A l'heure de la toilette et des repas, l'assistance de l'infirmière devient

donc essentielle. Pour lui assurer le plus de confort possible, elle lui donne, après le bain quotidien, la position assise et au besoin, dans la journée, replace couvertures et oreillers. Pour les repas, elle évite la précipitation: elle fait manger l'enfant lentement et par petites bouchées en tenant compte de ses goûts et préférences. Une diète hypervitaminée fut prescrite pour tonifier l'état général.

Le bien-être mental est aussi nécessaire pour obtenir l'efficacité du repos physique. Il faut donc maintenir une atmosphère de calme. A la moindre contrariété, il se produit chez l'enfant une accentuation des symptômes plus haut mentionnés. Pour ménager cette trop vive émotivité, l'infirmière essaie de lui rendre la vie paisible non moins qu'agréable. Elle s'intéresse à ses questions. Elle lui explique d'une façon simple ce qu'il veut connaître. Elle tâche de l'occuper avec des livres d'histoires, des jouets, etc.

Pendant les 48 heures qui précédèrent l'opération, on lui donna les médicaments suivants dans un but prophylactique:

*Supp. créo-rectal:* Suppositoire à la créosote appliqué deux fois par jour. Ce médicament a une action antiseptique sur les voies respiratoires. Parce que la créosote tend à irriter la muqueuse gastrique, on l'administre ordinairement par voie rectale en émulsion sous forme de suppositoire.

*Redoxon:* A la dose de 500 mg. par voie I.M. deux fois par jour. La vitamine C ou acide ascorbique s'avère indispensable à la formation des globules rouges.

*Chlorure de thiamine:* A la dose de 100 mg. par voie I.V. deux fois par jour. La thiamine ou vitamine $B_1$ est un tonique nervin. En agissant directement sur le système nerveux, elle favorise toutes les opérations organiques. De plus, c'est une vitamine qui ne s'accumule pas dans l'organisme; il faut donc la donner par voie parentérale quand l'alimentation est suspendue.

*Soluté glucosé 5%:* 500 cc. par voie sous-cutanée la veille de l'opération. Donné dans le but de prévenir la déshydration qui pourrait survenir à la suite de la grande perte de liquides subie par l'organisme pendant l'opération. Quand on ajoute à ce soluté une quantité minime de Widase, on en facilite l'absorption.

La préparation à toute opération comprend un lavement évacuant donné la veille. Pour un enfant, on donne de 150 à 200 cc. d'eau savonneuse, ce qui stimule le péristaltisme intestinal et provoque l'évacuation des matières fécales. A cause de la cardiopathie, on procéda très lentement en ayant soin de rassurer notre malade.

Afin d'éviter tout état d'hypernervosité, on fit prendre à l'enfant la veille de l'opération, au coucher, ¾ de gr. de nembutal per os. Ce médicament, un barbiturique, agit sur le système nerveux central en produisant un sommeil calme.

Le matin de l'opération, on fait la toilette du petit malade comme à l'habitude mais on le garde à jeun. Une médication préanesthésique est ensuite administrée: morphine 1/36 gr. et atropine 1/250 gr. en injection S.C. La morphine provoque un état de somnolence et l'atropine y est associée pour en prévenir les mauvais effets: nausées, vomissements, sécheresse des muqueuses. La dose ordinaire, morphine 1/4 et atropine 1/150, fut diminuée à cause de l'état et du jeune âge de notre malade.

Grâce à cette sédation, c'est dans un état de demi-conscience que le petit Raoul fut transporté, dans son lit, à la salle d'opération. C'est là que l'on vit à la préparation du champ opératoire.

L'anesthésiste jugea bon de faire une anesthésie générale intratrachéale. En plus des substances anesthésiques, on donna au malade pendant l'opération une transfusion sanguine de 1,000 cc. et un soluté physiologique et glucosé 5%, 1,000 cc., afin de réparer les pertes de l'organisme. Il fallut aussi administrer de l'oxygène presque continuellement.

L'opération qui débuta par une thoracotomie latérale gauche dura cinq heures. Le protocole opératoire nous dit que l'artère pulmonaire est trouvée plus petite que normalement mais sans atrésie; sa face postérieure, immédiatement en amont, repose sur l'aorte descendante. La sous clavière aurait été de calibre suffisant mais sa longueur semble douteuse. Le chirurgien libère donc l'aorte descendante avec une ligature double, sectionne les 3e et 4e artères intercostales et pratique l'anastomose de l'aorte avec l'artère pulmonaire.

L'opération terminée, l'enfant fut

immédiatement déposé dans son lit et transporté à la salle de surveillance post-opératoire. Cette dernière, sous la direction d'infirmières diplômées, est un endroit aménagé spécialement pour les soins immédiats à donner après une opération. Notre petit opéré y est l'objet de soins attentifs pendant quatre heures. Son pouls, sa respiration, sa tension artérielle sont notés régulièrement. On lui administre de l'oxygène par masque et l'on continue le soluté installé à la salle d'opération. Au bout d'une heure, le malade commence à s'éveiller: il s'agite et accuse une diaphorèse intense.

Vers 5:00 p.m., on le juge apte à être ramené à sa chambre. Pendant le transport, on continue de lui donner, par masque, de l'oxygène à l'aide d'un ballon portatif. Aussitôt rendu à sa chambre, on lui donne la position latérale gauche. Afin de pouvoir prendre la T.A. prescrite aux demi-heures, on fixe au bras droit un brassard pour le laisser en permanence. La T.A. varie quelque peu aux environs de 100/50. La pulsation, faible mais régulière, se maintient à 120. La respiration est à un rythme de 36 à la minute. La coloration est déjà meilleure qu'avant l'opération. La diaphorèse persiste jusqu'au soir.

On place l'enfant, dès son retour, sous une tente d'oxygène. Afin d'y maintenir la concentration voulue, on fixe solidement les côtés sous le matelas pour ne pas que l'oxygène puisse s'échapper. Les deux fermetures-éclairs, dont la tente est munie, permettent de pouvoir aux besoins du malade en n'abaissant que très peu la concentration surtout si on a soin d'arrêter le mécanisme de fonctionnement avant de les ouvrir.

La position du malade doit être changée aux heures. Après une heure, on profite de cette occasion pour faire exécuter au malade les exercices respiratoires prescrits dans le but de prévenir les complications d'ordre pulmonaire. Pour faciliter l'expectoration des sécrétions, l'infirmière aide le malade à se mettre en position horizontale pour cinq minutes pendant lesquelles il s'efforce de tousser et de cracher. De plus, en appuyant fermement la main sur l'hémithorax opéré, elle diminue de beaucoup la douleur qui est inévitable.

Après une heure, le petit Raoul est presqu'entièrement éveillé. Sur sa demande, on lui donne quelques gorgées d'eau tiède. La douleur à la région opérée se fait bientôt sentir. Sur prescription du médecin, on lui administre alors, par voie I.M., 25 mg. de demerol. Ce médicament, un produit synthétique de même nature que les opiacés, soulage rapidement notre malade qui repose par la suite.

Pendant ces premières heures, rien ne doit échapper à l'oeil attentif de l'infirmière. Sa présence auprès du malade est nécessitée presque continuellement et sa vigilance ne saurait jamais être trop grande. Pendant cette période critique, les cardiologues et les chirurgiens apportèrent aussi à l'enfant une étroite surveillance.

A l'opération fit suite un drainage thoracique qui dura quatre jours. Ce drainage se fait par une sonde Petzer placée dans le thorax et communiquant avec une bouteille au moyen d'un tube de rallonge. Deux embouts de verre pénètrent dans la bouteille: l'un est une prise d'air et l'autre, baignant dans une certaine quantité d'eau, facilite le drainage. La pression ainsi exercée empêche la communication directe de l'air extérieur dans la cavité pleurale, ce qui provoquerait un pneumothorax spontané. Pendant les différentes manipulations, on interrompt momentanément le drainage par deux pinces hémostatiques placées près de la plaie pour prévenir l'emphysème possible. Une compression sur le tube ou tout autre petit obstacle peut bloquer le drainage. En ce cas, une instillation d'eau stérilisée de quelques cc. dans le tube de drainage doit être faite. Le liquide drainé est de couleur rouge claire au début. Sa quantité quotidienne, 250 cc. la première journée, est dosée exactement et notée au dossier avec les liquides excrétés. Le dosage des ingestats est aussi fait rigoureusement.

La première nuit se passa d'une façon normale. La surveillance du pansement ne démontra aucune hémorragie de la plaie. Vers 11:00 p.m., le malade eut une miction naturelle de 250 cc. On dut répéter souvent le demerol pour soulager l'enfant qui se plaignait beaucoup.

A ces injections, faisaient suite des périodes de sommeil qu'on dût malheureusement interrompre aux heures pour changer la position et faire exécuter les exercices respiratoires.

A 7:30 a.m., c'est un petit garçon encore affaissé que l'infirmière en service de jour trouve à son arrivée. Après les soins usuels du matin, elle lui offre cependant une diète liquide que le malade ingurgite avec plaisir. Pendant cette première journée, sur l'ordre des médecins qui vinrent le visiter maintes fois, on continua de lui donner de l'oxygène sous tente. On continua aussi les injections de demerol aux quatre heures. Un autre soluté physiologique et glucosé 5% fut prescrit et donné par voie S.C. avec addition de Widase. Les médicaments suivants furent de plus administrés:

*Pénicilline aq.:* 50,000 unités en injection I.M. aux 4 heures pendant 3 jours. La pénicilline est un produit de métabolisme d'un microorganisme qui, par sa présence, inhibe la vie ou la croissance d'autres microorganismes. Cette action est le phénomène de l'antibiose.

*Dihydro-streptomycine:* ½ gm. en injection I.M. 4 fois par jour pendant 3 jours. Autre antibiotique de découverte plus récente que la pénicilline. Contrairement à cette dernière, agit surtout sur les microbes gram négatifs. La streptomycine, quand elle est en solution aqueuse, est moins toxique pour l'organisme.

Les injections de *chlorure de thiamine* et de *Redoxon* ainsi que les suppositoires à *la créosote* furent aussi continués pendant quelques jours.

La deuxième journée, le chirurgien, à sa visite, constate une amélioration dans l'état de son malade. Ce dernier remue facilement dans son lit et peut même changer de position seul. On continua donc de lui donner de l'oxygène que par intervalles et au moyen d'un masque. De se sentir ainsi libéré de la tente, notre petit opéré devient de meilleure humeur: il répond gentiment à nos questions et se plaint de moins en moins. La position Fowler lui est permise et la diète est augmentée progressivement.

Au troisième jour, le drainage thoracique est enlevé et l'état continue de s'améliorer. La température est redevenue normale, la pulsation et la respiration sont à un rythme moins accéléré. On donne un lavement évacuant afin de libérer l'intestin, ce qui soulage aussi grandement le malade.

Au quatrième jour, notre petit Raoul, avec de l'aide, s'asseoit dans un fauteuil. Comme il s'y sent très confortable et ne présente aucun signe de fatigue, il répète son exploit plusieurs fois dans la journée. Le lendemain, il fait quelques pas et, au sixième jour, il circule seul.

Une amélioration de son état est maintenant bien visible: il est moins nerveux et moins anxieux. Le chirurgien est satisfait de l'anastomose car la coloration des téguments est normale. Dix jours après l'opération, le congé en chirurgie est accordé et Raoul s'en retourne au service de pédiatrie.

Une convalescence heureuse doit comprendre un bien-être physique et mental. Des périodes prolongées de repos dans une chambre claire, bien ensoleillée, contribuent à redonner à notre malade le goût d'une vie semblable aux autres enfants de son âge.

On lui donne une alimentation normale. Tous les éléments nécessaires à la croissance de ce jeune organisme sont présentés d'une façon équilibrée et appétissante. Maintenant, Raoul, qui circule librement, prend plaisir à s'amuser avec les autres enfants.

Son régime de vie est normal. Cependant, il faut continuer d'éviter les contrariétés et les trop vives émotions. Une vie calme sera toujours nécessitée par l'état de cet enfant. Une hygiène rigoureuse, bonne alimentation, repos suffisant, activité modérée, examen médical périodique, devra être observée pour prévenir les troubles d'ordre général car l'organisme de notre petit malade sera toujours en état de moindre résistance.

Cependant, afin de rétablir le plus possible toutes les fonctions organiques, on lui donne, pendant sa convalescence, les médicaments suivants:

*Digitaline Na.:* 5 gouttes in aqua trois fois par jour. Ce médicament a une action tonifiante sur le muscle cardiaque. Par la pulsation prise minutieusement, on peut en constater l'effet. L'action est cumulative et les symptômes d'intoxication à surveiller sont les suivants: bradycardie, nausées, vomissements.

*Phénobarbital:* .01 gm. trois fois par jour. Ce

médicament a une action dépressive sur le système nerveux central. Donné à dose filée, il prévient la grande nervosité souvent présente chez les personnes hospitalisées. Pour notre malade, ce médicament est de première indication.

*Fertinic:* Un comprimé trois fois par jour. Composé ferreux. L'hémoglobine doit au fer l'essentiel de sa formation. Ce médicament prévient donc l'anémie. A dose inconsidérée, il produit des troubles digestifs, des selles noires, et parfois des éruptions cutanées. Une précaution particulière doit être apportée dans l'administration de ce médicament: il ne doit pas venir en contact avec les dents car le fer en détruit l'émail.

*Rx 55:* Un comprimé trois fois par jour. Ce composé vitaminique (A-B-C-D-) a une action bienfaisante sur toutes les fonctions de l'organisme.

A la fin de mars, Raoul quitte l'hôpital pour une maison de convalescence où le service médico-social l'a placé. Après un séjour de quelques mois en cet endroit, notre petit convalescent ira vivre les mois d'été à la campagne dans une famille qui a accepté, sur les instances d'une agence sociale, de lui procurer cet avantage. A l'automne, il pourra sans aucun doute entreprendre une année scolaire.

C'est avec regret que nous avons vu Raoul quitter l'hôpital car, pendant son long séjour parmi nous, tous nous nous étions vivement attachés à lui. Cependant, de le voir partir dans un état si encourageant, nous ne pouvions que nous réjouir de son bonheur. Son histoire est une autre preuve que la chirurgie moderne, parce qu'elle entreprend des opérations audacieuses, obtient des résultats prodigieux.

## Lip Reading

In order to lip read nature demands that certain conditions be met. A lip reader must feel the speech sensations and allow his mind to cause the movements seen to follow one another just in the way they did when he could hear. As long as we know speech we have in our memory what we need to learn to lip read. No other authority, apart from our own careful self-observation, will prove to us the truth of this statement. Lip reading is a personal experience that we learn by doing.

Lip reading is not based alone upon what the eyes can see on the mouth but also upon the feeling of the complete motion of the speech muscles. The lips are but one part of the speech muscles but a prominent part and, while no sound reaches the brain through the ears, nevertheless speech will be evident. Speech involves not only the motion of the lips but the throat, tongue, teeth, cheeks, and every portion of the mouth.

Speech has three physical forms: (a) feeling the motion; (b) seeing the movements on the mouth; (c) hearing the sound of the motion. These forms are so closely connected with speech that they cannot be differentiated in our memory, any more than we can separate thought from spoken words. The sound and sight forms are purely sensory and imply the motion; the feeling form is more complete in itself, so that we can reconstruct another person's speech with the feeling sense alone.

Everyone can feel speech, as thoughts pass before the mind, just as if they were heard. Stop and prove this fact. Shut your eyes and lips and relax completely.

1. *Think* the thought—*Spring flowers are beautiful*

2. Keep your eyes closed and *speak* the words out loud.

3. Imagine the mouth of another person repeating the words with you in unison.

4. Make the effort to shout the thought to someone far away.

5. Just think the words again quietly and notice whether you feel any sensations of motion.

6. When you are sure you feel the oral sensations, imagine some other person saying the words to you. If you see what you feel you are lip reading.

The skill of lip reading is to maintain the the needed harmony between the mental and physical processes. It will be readily realized that the hearing of even a little sound, whether or not a hearing aid is used, will help the other senses to grasp what is being said.

—M. FAIRCLOTH in *The Hearing Eye.*

# Trends in Nursing

## Committees

With the new biennium well under way now, we find activity in nursing affairs increasing day by day.

The Committee on Public Relations, under the chairmanship of Miss Mildred Walker, is eager to continue the work of bringing the importance of nursing and nursing affairs to the attention of the public and to those C.N.A. members who do not have or do not make use of opportunities to know their association better. There are still many fields of public relations in nursing which are as yet unexplored.

The Committee on the Code of Ethics, whose chairman is Miss Elizabeth Logan, is gathering statements of opinion from the provincial associations in order to have a foundation upon which to work. Its objective is to prepare a code for Canadian nurses which will embody those nursing ethics which are particularly applicable to our own situation. As can be imagined, this involves a great deal of studying of the intangibles of nursing practice and much discussion concerning the inclusion of seemingly outmoded conventions

## Lord Report

We, in National Office, have been interested to note the number of requests from outside of Canada for the Lord Report on the Evaluation of the Demonstration School. This shows the increasing recognition of the C.N.A for its sponsorship of the Metropolitan Demonstration School at Windsor. The latest request was from Denmark where the authorities are planning to shorten their course in general nursing but wish first to be able to study the Lord Report of the Evaluation. As Dr. Lord's report was favorable it may well be that the Canadian Red Cross—C.N.A. joint venture will go down in history as being a turning point in nursing education.

## Structure Study

Requests are still coming in for copies of the Structure Study. This is an indication of the plans of many districts and chapters throughout Canada seriously to study the report during this biennium in order to vote intelligently at the next general meeting at Banff in 1954. We heartily endorse this action and hope that all C.N.A. members have access to a copy and plan to attend meetings at which it will be discussed.

## Canadiana

There has been a sudden increase in requests for our two publications—"Digest of Provincial Board Rules and Nurse Registration Acts" and "How to Choose a School of Nursing." The mystery was solved when we received a marked copy of "Canadiana" which listed these two C.N.A. publications. This booklet lists publications of Canadian interest each month and is available free to public libraries and upon subscription to others. It is prepared by the Canadian Bibliographic Centre, Public Archives, Ottawa, Ont.

## Audiovisual Aids

The Nursing Advisory Services for Orthopedics and Poliomyelitis have announced that their revised series of 2" x 2" slides on the care of the infant with clubfoot and on plaster casts will be available for sale and loan on December 1, 1952. The series on clubfoot consists of 25 black and white or Kodachrome slides; that on plaster casts of two sets one of 39, the other of 28 Kodachrome slides. The same organization has also available a new series of films entitled "Nursing Care in Poliomyelitis," consisting of three half-hour 16 mm. sound films. More information may be obtained from the *Nursing Advisory Services for Orthopedics and Poliomyelitis, National League for Nursing, 2 Park Avenue, New York City 16, N.Y.*

## Records from Demonstration School

Because of the complete cessation of operations at the Metropolitan Demonstration School at Windsor, all records have been moved to National Office. These include the permanent records on

each student who was admitted to the school. Consequently *requests for transcripts in connection with reciprocal registration, applications for positions, and similar reasons will be completed* by the professional staff of National Office.

## Faking Casualties in First Aid

During the recent National Conference of the St. John Ambulance Association, one evening was spent on Civil Defence demonstrations. One fascinating part of the display was the very "real" appearance of the casualties. They were examples of the recently developed art of make-up applied to practice in first aid. Burns, lacerations, and compound fractures were so natural in appearance that it was startling to hear the victims speaking in normal, healthy voices instead of being in a state of deep shock. This method of introducing an appearance of reality into practice for emergency work should do much to lessen the emotional reaction of the first-aider at his first accident and to make him better able to assess the damage. The St. John Ambulance Association stresses, though, the need to bear in mind that the faking is merely the means to an end—the end being first aid practice.

## Atkinson Grant to V.O.N.

With the increasing responsibility of the V.O.N. nurse for the rehabilitation of her patients upon their earlier discharge from hospital, a need has been felt for specific training. Victorian Order nurses in Ontario will be given a better understanding of the newer methods of nursing care that incorporate the principles of maximum physical restoration with every type of illness. A grant of $7,500 from the Atkinson Charitable Foundation will help to finance a series of demonstrations and lectures at Hamilton, Ottawa, Toronto and Windsor. Branch members will leave for the allotted centres alternately until all have participated.

The content of the demonstrations will be directed along three main avenues:

> Care of patients with long-term illnesses; early recognition of crippling conditions in every type of illness and techniques to combat them; and prevention of fatigue among the nurses themselves by correct posture and scientific application of their own physical activities.

The V.O.N. headquarters at Ottawa, in addition to planning the project and obtaining the qualified instructors, will generally supervise all the arrangements and assess the results with a view to making the training national in scope.

## I.C.N. Congress in Rio de Janeiro

Mrs. Clerk, the C.N.A. convention manager, has sent to I.C.N. Headquarters, London, England, for official application forms for those members interested in attending the congress in Brazil. Thomas Cook & Son, official travel agents, are in the process of printing the official pamphlet outlining itineraries and costs, and including suggestions for suitable clothing for the prevailing climate. On receipt of applications to National Office at *Suite 401 1411 Crescent St., Montreal 25*, a copy of this pamphlet and the application form will be forwarded to the applicants.

## Orientation et Tendances en Nursing

### Les Comites

Maintenant que les préparatifs du congrès biennal sont bien en voie, les activités dans le nursing augmentent de jour en jour.

Le Comité des Relations Extérieures, sous la direction de Mlle Mildred Walker, désire ardemment continuer à travailler à faire connaître l'importance des activités du nursing au public et aux infirmières, membres de l'Association des Infirmières Canadiennes, qui n'ont pas eu l'occasion, ou qui n'ont pas su en profiter de mieux faire connaître leur associa-

tion. Pour ce qui concerne le nursing et les relations extérieures, bien des avenues n'ont pas été explorées.

La préparation d'un code de morale professionnelle sera l'objet d'une étude d'un comité sous la direction de Mlle Elizabeth Logan. Actuellement le comité est à recueillir l'opinion des associations provinciales afin d'établir une base pour leur travail.

Le but du comité est de préparer un code à l'usage des infirmières canadiennes sur les points de morale s'appliquant particulièrement à leur état. Comme on peut se l'imaginer, ce travail exige une étude considérable de la conduite de l'infirmière et de nombreuses discussions sur ce qui de nos jours conserve une importance ou est devenu inutile dans l'application.

### Le Rapport Lord sur l'Ecole de Windsor

Le personnel du Secrétariat National a remarqué avec un vif intérêt les nombreuses demandes parvenant de l'étranger du Rapport Lord sur l'évaluation de l'Ecole de Démonstration. Cela prouve que l'on reconnaît de plus en plus le rôle important joué par l'A.I.C. dans l'expérience dont le Metropolitan Demonstration School de Windsor a été l'objet. La dernière demande vient du Danemark où les autorités se proposent de raccourcir le cours de base mais, avant de le faire, l'on veut étudier le rapport de l'évaluation. Comme d'après le rapport du Dr. Lord, l'expérience a été jugée bonne, il se peut que l'entreprise hasardeuse de la Croix-Rouge Canadienne et de l'A.I.C. passe à l'histoire et soit considérée comme un tournant de la formation de l'infirmière.

### Etude de la Structure de l'A.I.C.

L'on nous demande encore des exemplaires du rapport de l'étude de la structure de l'A.I.C. Cela indique que dans bien des districts et chapitres du Canada, l'on se propose de faire une étude sérieuse du rapport afin de voter intelligemment au prochain congrès biennal de Banff en 1954.

### Canadiana

Comment expliquer l'intérêt soudain manifesté par tant de gens envers nos deux publications: "Résumé des Règlements et des Lois d'Enregistrement des Infirmières" et "Le Choix d'une Ecole d'Infirmières"? La clef du mystère nous parvint avec un numéro de "Canadiana." Ce livret donne la liste de toutes les publications ayant un intérêt particulier pour les Canadiens. "Canadiana" est publié par le *Canadian Bibliographic Centre, Public Archives, Ottawa, Ont.* Il est envoyé gratuitement aux bibliothèques et sur abonnement.

### Projections Sonores

Le Service Consultatif en Nursing pour l'Orthopédie et la Poliomyélite a annoncé une nouvelle série de projections de 2″ x 2″ sur les soins à donner aux enfants affligés d'un pied bot et la correction de cette malformation pas appareils plâtrés. La série sera mise sur le marché le 1er décembre 1952 pour vente ou location.

Le même organisme offre une série de films sur les soins en poliomyélite. Pour renseignements bien vouloir s'adresser à *Nursing Advisory Services for Orthopedics and Poliomyelitis, National League for Nursing, 2, Park Ave., New York City 16.*

### Les dossiers de l'Ecole de Demonstration de Windsor

Toutes les activités de "Metropolitan Demonstration School" de Windsor, ayant complètement cessées, les dosiers ont été transportés au Secrétariat National. Chacun des dossiers des étudiantes admises à l'école s'y trouve donc. Conséquemment toutes les demandes concernant le contenu de ces dossiers, extrait en vue de l'enregistrement par réciprocité, pour l'obtention de positions et pour raisons semblables devront être faites au Secrétariat National.

### Des Pseudo–victimes et les Soins d'Urgences

Durant la conférence nationale de l'Association Ambulancière St-Jean, une soirée fut consacrée à la défence civile. La démonstration portait sur les soins d'urgence à donner en cas de désastre. Les blessures de supposées victimes avaient une apparence si réelle que l'auditoire en fut saisi. Le but de l'Association Ambulancière St-Jean était de fixer dans l'esprit de chacun la nécessité de savoir appliquer les soins d'urgence.

### Un don a la V.O.N.

La réhabilitation des malades, après un séjour de plus en plus court à l'hôpital, est une nouvelle responsabilité qui incombe aux infirmières de la V.O.N. Les infirmières de l'Ontario vont avoir une meilleure compréhension des nouvelles méthodes employées pour assurer un parfait rétablissement de la santé, quelle que soit la maladie dont le malade ait été atteint. Un don de $7,500 a été fait par l'Atkinson Charitable Foundation dans le

but d'aider à payer une série de démonstrations et de conférences données à Ottawa, Hamilton, Toronto et Windsor. Toutes les infirmières se rendront à tour de rôle dans ces divers centres. Le programme des démonstrations porte sur trois points principes: Soins aux malades chroniques; reconnaissance durant la maladie des signes les plus reculés pouvant conduire à une infirmité et les moyens d'y remédier; prévention de la fatigue chez les infirmières par un bon maintien et par une application des principes scientifiques dans leur travail.

### Le Congres du Conseil International de Rio-de-Janeiro

Toutes les infirmières intéressées à assister au Congrès du C.I.I. au Brésil voudront bien communiquer au *Secrétariat National, Suite 401, 1411 rue Crescent, Montréal 25.* Les formules d'admissions, les renseignements concernant l'itinéraire, le coût, etc., seront bientôt à la disposition des membres.

## New School for Nursing Aides

DURING THE past year, construction has been progressing on a new building on provincial property which is now partly occupied by the University of Alberta (Calgary Branch) and by the Provincial Institute of Technology and Art. This work has now been completed and a white stucco building of two stories is now occupied as the School for Nursing Aides with the main entrance at *1315 - 16th Ave. N.W., Calgary*. This building is in the shape of an "L" with the main entrance at the centre of the building. The stair-well is lighted by large panels of windows extending from floor to roof.

On the ground floor is located the students' lounge, an auditorium which is used for first aid, health and recreation classes, and a projection room for teaching films and for student meetings. A medical examination room, in attractive red and gold coloring, is equipped with refrigerator, autoclave and instrument sterilizer. Here, also, the immunization clinics are held and health services of the school are operated. A classroom, equipped with 38 tablet-arm chairs, also has a skeleton, x-ray viewing box, and Latex torso model with removable parts used for instruction in anatomy and physiology.

Accommodation for 160 students is provided in a large locker room. Adjoining this room is the students' lavatory with basins, showers, and toilets.

The housekeeping department is planned so that there is adequate space for storage of all uniforms and aprons in stock and also the handling of laundry for the school and students in training. All deliveries are made at a rear entrance to this department. A separate room holds all cleaning equipment and supplies.

On the second floor is a general office with work space for two stenographers, library and reference facilities for the staff, and two adjoining private offices. There is also equipment for preparing our own instructional material and producing it at the school. Next to the office is an attractively furnished staff lounge with separate locker room. Teaching space is provided for 20 students in the cookery laboratory. This lab. is complete with refrigerators, individual teaching units, stoves, sinks, dishwashing facilities, laundromat, drier, ironer, and storage cupboards. Another classroom on this floor is equipped to accommodate 38 students.

The teaching space allotted to nursing procedures is attractively furnished. The two identically equipped practice rooms have green chalk boards and tablet-arm chairs at one end and seven beds and a child's cot at the other end of the room. Water and all necessary practice equipment are in each procedure room. Immediately outside the procedure room door is a large supply room for linen and extra teaching equipment, which is available to both practice rooms.

Another room gives change-room space to the students who are acting as patients. Here they may leave their bath blankets, gowns and dressing gowns in assigned shelf space. A laundry chute saves many steps with soiled laundry by delivering it to the first floor where it falls into a wheeled laundry hamper in a special wall cupboard.

The whole school is attractively designed. Some rooms are paneled in blonded birch with a butternut finish while in others colors are attractively blended. Everywhere, the lighting fixtures and large glass brick windows provide adequate lighting.

The atmosphere of the whole building is cheerful, bright, and very conducive to effective classwork and study.

J. F. Ferguson, R.N.
*Supervisor of Training*
*School for Nursing Aides*

# Easing the Burden of the Sick

WENDY HALL

The elderly woman, lying in hospital after an operation, needs stamps and notepaper so that she can write to her only son serving overseas; the father of a family, after six months' illness, needs skilled advice about his mortgage payments which have fallen behind. Both are patients in State-owned hospitals. To whom do they turn for stamps and advice? To the State, as represented by its employees on the staff of the hospital, or to private individuals like themselves?

There, in essence, is the question which many pondered when the State took over ownership of the hospitals of Britain in 1948. Could voluntary service, which the people of Britain believe to be essential to the working of democracy, and State control exist side by side? it was a question which raised itself in many spheres where the State came face to face with sheer human problems. Nowhere was it more urgent than in the hospitals. Happily, it soon became clear that not only was the partnership possible but that voluntary service was more useful than ever to the smooth running of the hospitals.

The State had realized from the outset that its own potential impersonality must be counterpoised by the humanity of the voluntary worker. According to a report of an investigation by the independent and non-party National Council of Social Service, "the humanity and vitality of the hospital service today is due to the decision of Parliament in creating a national service to make full use of voluntary effort."

Voluntary effort finds expression in an enormous variety of forms. The patient—the most important person in the hospital—sees it in the impressive volume of unpaid, spare-time work done by private citizens. The work is not impressive in itself; it is often menial, seemingly trivial. Yet it consists of the small things which mean so much to the sick—the small things for which no Act of Parliament or Ministerial edict can, or should, legislate.

The stamps and the notepaper, the toothbrushes and the toothpaste, which every patient needs, are brought round on "trolley shops" by voluntary workers. Skilled advice on financial and legal problems which may be causing worry and impeding recovery is freely given by qualified citizens. Many people regularly visit hospitals to write letters for those too sick to do it for themselves; others man the library service provided for hospitals by the St. John Ambulance Brigade and the British Red Cross Society—both voluntary bodies. Where hospitals have their own libraries, these are staffed by volunteers, and their torn volumes re-bound from time to time by another group of spare-time workers. And these are only a few of the ways in which private citizens try to ease the burden of the sick.

In many hospitals volunteers supplement the nursing strength. St. John and Red Cross members, trained in first aid and home nursing, often give a day, half a day or an evening every week, when they help with bed-making, washing patients, and other jobs within their competence. Volunteers without nursing training act as ward orderlies, tidy patients' lockers, arrange flowers, help with washing up and serving meals. As long as the current shortage of nurses persists, the help given by these private citizens—many of them housewives who snatch a few hours a week away from home and children—is invaluable.

Outside the hospitals, but closely connected with them, is a mass of work which can be done only by volunteers. The Blood Transfusion Service, which has saved so many lives, is organized on a purely voluntary basis. Men and women with cars hold themselves in

Miss Hall is an English journalist and feature writer.

readiness to drive relatives to visit patients in hospitals. Organizations, such as the Women's Voluntary Services, run a "home-coming service" which eases the difficult period when patients are well enough for discharge from hospital but not sufficiently strong to look after themselves. This is particularly valuable to old people without relatives nearby to care for them; for old people, too, the "meal on wheels" service, run by various voluntary organizations in different areas, to deliver hot meals at the patient's door has proved a boon and a blessing.

This voluntary service, personally given and personally received, represents the continuation and extension of long-established practice. On the administrative level, a new principle has been adopted. The hospitals, though State-owned, are administered by voluntary committees, whose members, drawn from all walks of life, serve in this voluntary way.

This partnership of the bureaucracy and the voluntary spirit brings its inevitable working difficulties and problems but it has proved its importance and its value. It provides a pattern in which both the State and the individual can make their best contribution to society and its welfare.

## Development of Teamwork

A one-day institute was held in Welland, Ont., on October 18, 1952, with 35 nurses from the district in attendance. The purpose was to promote a closer working relationship among all nurses in this area. Those participating in the conference included nurses from private nursing, industry, hospitals, the Victorian Order of Nurses, from the official health unit and doctors' offices.

A highlight of the program was the presentation during the morning of a dramatized sketch of a family conversing amiably after the evening meal. This demonstrated problems indicating the need for better correlation of services. For discussion, members were divided into small groups.

This institute was a pioneer venture in bringing together all branches of nursing in a community for a day to consider more effective cooperation.

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Women's responsibilities in international affairs are much discussed today, and are of the first importance. We all, of course, desire peace but I find the arguments that women will promote peace by womanly interests and by womanly virtue unconvincing. Women's loyalties and affections can be channelled just as easily into a narrow regard for their families, a narrow partyism, and a narrow nationalism, as into any broad love of humanity. In fact, our practical instincts rather invite us to the narrow, the concrete, the apparently attainable objective.

It might be argued that women should take particular pains to keep informed on international affairs just because our personal and intimate interests sometimes make abstract problems distasteful to us and because, being uninformed, we can all too easily be stampeded into a narrow emotional viewpoint. Ample information and a broad understanding should help women to reject narrow and personal interpretations and to bring imagination and sympathy to bear intelligently on human problems. They can then use their practical administrative talents, which are much needed, on projects where time and money are so easily spent and so often wasted. This is an area where women's organizations could and should make an important contribution.

Women in the modern age of their emancipation are intellectually and emotionally competent, as they always have been. They now operate in a much larger social frame and some women have not realized, perhaps, that the frame is larger. Free and responsible, they must sum up all their assets and liabilities of character, of intellectual ability, of knowledge and experience, of economic and social position; and they must then devote themselves disinterestedly and intelligently, without self-consciousness, to the difficult and arduous tasks that confront free people everywhere. This is no time for feminine indolence or for masculine vanity. There is so much to do and for doing it there is so little time.

—Dr. Hilda Neatby for the
*Canadian Association for Adult Education*

*Student Nurses*

# Why I Chose Psychiatric Nursing

ANNE DENISON

WHILE ATTENDING high school the thought of nursing was furthest from my mind. All psychiatry meant to me was a word I had difficulty in spelling and pronouncing and I never was sure of its exact meaning.

Only after spending sometime in the humdrum business world did any thoughts of nursing occur. I realized what a small amount of service I was giving to my community adding rows of figures day by day and life became a bit uninteresting!

It was around this time that I had my first introduction to the nursing field for I fell ill with appendicitis and ended up in hospital. Here I became intrigued with the glamorous side of nursing. Fortunately, for me, this episode took place before the days of early rising for post-operative cases and hence I enjoyed nursing care at its best. Then I began to think what a satisfying life these young nurses must lead and their feeling of accomplishment at the end of the day. My interest was actively aroused.

When I was about ready for discharge I began to have very strange and new thoughts. The slightest thing annoyed me to the utmost and several times I felt like throwing the nearest object at hand. While trying to think up an explanation for these queer emotions, the often-used expression, "When people are ill physically, they are ill mentally," came to my mind. If such a minor thing as a little surgery could upset me, what must major surgery and long duration medical disorders do to people with less emotional control than I? Thus a branch of medicine to which I had given little thought was opened to me.

Miss Denison graduated last year from the Ontario Hospital in Kingston.

I knew there were psychiatric schools of nursing in my province as a close friend had graduated from one of them. Both she and my sister, who had had experience in a psychiatric hospital, encouraged me with my new idea. At first members of my family were a bit dubious but after careful thought gave their approval to the course.

Many people are under the impression that psychiatric nursing is a most depressing profession. This I have found is untrue. In the beginning it did seem so but I soon learned by experience to keep thoughts of the future foremost. One must learn to look for the results of one's work, not immediately but perhaps many months ahead.

As students, we were given clinical pictures of the different psychoses in our psychiatric nursing lectures. Then on the wards, working with the patients, we were able to recognize the various symptoms they portrayed, characteristic to their illnesses. Following these patients from day to day, supervising their eating and sleeping habits, their recreation and general health I became absorbed in them and their futures. I could not help but become very much attached to these people because their personalities, no matter how bizarre, made a lasting impression.

One learns many things. Patience, self-control, and understanding both of patient and self are very important. One learns to understand the factors which lead to the development of the patient's personality. A psychiatric nursing course enables a nurse to recognize behavior disorders and what may be done toward the prevention of mental illness. From this I have learned also to understand myself—to recognize and overcome my own difficulties.

It is a challenge to nurse a manic-depressive patient through an excited phase wherein one must consider his physical and mental health. He has not time or inclination to eat or sleep or keep clean and may do considerable harm to himself or to other people. Then, when these same patients go through the opposite or depressed phase, one must be alert to guide him through his illness with the same intricate care.

To try to break down the wall with which the schizophrenic patient surrounds himself is an interesting task. It is a goal to make the world from which he is retreating a more pleasant place to him. Assisting with all forms of treatments — continuous baths, shock therapies — and aiding with the patient's gradual return to normal is most stimulating and worthwhile.

All of the students in this psychiatric hospital spend a year in a general hospital and three months in a pediatric hospital. I have come to the conclusion that psychiatric training should be part of every student's training. In pediatrics many of the psychiatric principles are valuable in dealing with children. In general nursing they enable you to establish a much better relationship and understanding of your patients.

Never has the study of personality disturbances been approached from so many angles as during the past decade. I feel that psychiatric nursing, while it means giving more of oneself in the way of reassurance, kindness, and general understanding to the individual patient, is a very satisfying and rewarding field of nursing.

## What Makes a Professional Worker Professional?

Frequent reference is made to a "professional attitude" and "professional conduct" on the part of persons engaged in occupations classed as professions. Nursing is regarded as a profession. Nurses are expected to behave professionally. Professional conduct is not easy to define in a few words, but listed below are some of the characteristics associated with true professional status.

*The professional worker does not require close supervision or direction.* He directs himself. He plans his own activities. He works independently.

*The professional worker does not regard himself as an employee.* He does not consider himself to be working for a "boss." He regards his supervisors as fellow professional workers and they regard him in the same way.

*The professional worker does not work by the hour.* He does not expect to adhere strictly to a minimum time schedule. He adjusts his working hours to meet the necessities and and responsibilities of his duties, without thought as to "overtime" or "standard work week."

*The professional worker does not expect to be paid by the hour.* He expects the over-all sum for which he has agreed to perform his duties. This sum is based upon the responsibilities involved and the professional service rendered. It cannot be measured in hours. Professions whose members regularly demonstrate this are those where compensation is highest.

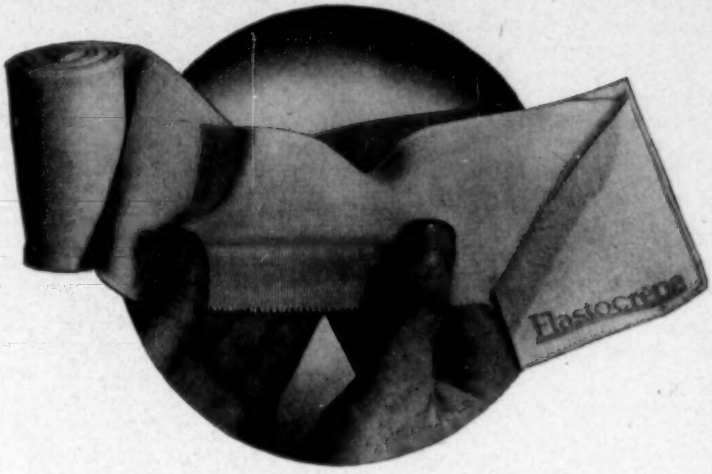
*The professional worker takes full responsibility for the results of his efforts and actions.* He makes his own decisions and acts upon them. He may seek advice and counsel but he does not attempt to transfer responsibility for his own mistakes to others.

*The professional worker continually seeks self-improvement.* He takes advantages of every opportunity to improve his knowledge and understanding in connection with his professional duties.

*The professional worker contributes to the skill and knowledge of the profession.* He develops new ideas, plans and materials, and gladly shares them with fellow workers.

*The professional worker respects the confidence of others.* The welfare of those he serves often requires that information concerning them remain confidential. He never violates this confidence.

*The professional worker is loyal to his fellow*

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*workers.* He nerve gossips about them nor about those he serves.

*The professional worker avoids rumor and hearsay.* He does not credit or repeat information received through the "grapevine." He secures information which is important to him directly from those authorized to release it.

*The professional worker adjusts his grievances through proper channels.* He discusses them directly and privately with those authorized to make adjustments. He refrains from complaining and grumbling to others.

*The professional worker meets his professional obligations.* He fulfills completely all agreements and obligations entered into with fellow workers, whether they are legal or moral obligations.

*The professional worker is sensitive to the problems of his fellow workers.* He always considers the effect of his actions on the welfare of fellow workers.

*The professional worker does not advance himself at the expense of others.* He strives for promotion and advancement in the profession only on the basis of superior preparation and worthy professional performance.

*The professional worker is proud of his profession.* He always reflects to those outside the profession a pride and satisfaction in the work in which he is engaged.

*The professional worker's chief desire is to render a service.* To improve men's welfare is the end toward which the professional worker devotes his career. The nursing profession should exemplify this to the highest degree.

—MR. LEIGHBODY in *Tech Training.*

## Annual Meeting in Manitoba

The meeting of the Manitoba Association of Registered Nurses, October 22-24, 1952, was held simultaneously with annual meetings of the Associated Hospitals of Manitoba and kindred hospital organizations. Early in 1952 when the M.A.R.N. endorsed the suggestion of the Associated Hospitals of Manitoba for joint planning in this way, it was realized that while some members are not associated with hospitals, the great majority are so employed or are indirectly concerned with hospital services and therefore would benefit by the opportunity of attending sessions of both associations. It was recognized that both organizations would benefit by a greater understanding of the objectives and activities of each.

For years the provision of nursing care and the administration of nursing services have been topics for discussion annually by both associations. Why not discuss them together? Hence came the agreement by all concerned that simultaneous annual meetings and joint general sessions would promote interpersonal relationships and mutual understanding of interdependent responsibilities to society.

### GENERAL SESSIONS

1. *Demonstration of casualty care in mass disaster:* This realistic demonstration of the set-up, management and care of casualties in an improvised first aid station was presented twice on the first day of the meeting — in the morning and evening — before capacity audiences.

2. *Looking at nursing service and nursing education:* National and provincial activities of vital interest and importance to nursing were presented, viz: "Metropolitan School of Nursing Experiment" by Miss M. B. Hart, director, School of Nursing Education, University of Manitoba. "Canadian Commission on Nursing," by Miss Helen G. McArthur, president, C.N.A. "Survey of Nursing Services in Manitoba," by L. E. Pettigrew, executive secretary, M.A.R.N.

These presentations revealed the serious efforts that are being made in our country to provide solutions for nursing problems which continue to beset all those concerned with the provision of nursing care.

3. *Can the problem of nursing staff shortages be solved?* The papers given at this session dealt with three aspects of this problem as indicated by their topics: "Have we an adequate nurse training program in Manitoba?" Miss L. E. Pettigrew, executive secretary, M.A.R.N. "Utilization of non-professional personnel in nursing serv-

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ices," Brigadier Gladys Gage, superintendent, Grace Hospital, Winnipeg. "Reports on hospital expansion, distribution of beds and services, and influence on nursing staff problem," Mr. Murray Ross, assoc. secretary, Canadian Hospital Council.

The first paper emphasized that an assessment of the adequacy of any training program is dependent upon a definition of the services the trainee is to perform, and that extensive research and study of the work which nurses now do is basic to planning for adequate nursing services in the future.

Brigadier Gage advocated much more extensive use of certified nurse assistants such as the licensed practical nurse, with clearly defined duties and responsibilities in each ward service to which they may be assigned. In the discussion from the floor it was apparent that as yet the majority of people, though concerned about the apparent shortage of nurses, are doing little, by study, to understand the basic elements of the situation, such as the need for definition of nursing duties, training and employment of more workers for non-nursing duties, society's demand for increased services, viz: its demand for a reduced work-week, financial subsidization for training programs, etc. Everyone is aware of the widespread concern about the adequacy of nursing services but that concern in the main appears to be shallow, localized and ineffective — ineffective because of a deficiency in understanding that nursing service resources are relative to (1) the total man and woman power resources, and (2) the standards of basic education of the country.

### Business Sessions

Three business sessions were held during which reports of past activities were given and plans for future activities discussed. In one session Miss E. M. Watts, acting president, noted the significant changes suggested in the Structure Study of the Canadian Nurses' Association. At another the members considered carefully a draft of the revised Act of Incorporation and By-laws of the Association which, after amendment in accordance with the discussion, was approved in principle. At the final

session, Miss E. M. Pepper, nursing consultant, Civil Defence Health Planning Group, Ottawa, and Miss Josephine DeBrincat, nursing co-ordinator, Civil Defence Health Services for Manitoba, reported on the objectives and the organizational planning for the provincial census of nursing resources for civil defence.

By resolution, the Manitoba Association of Registered Nurses reaffirmed its endorsation of holding the annual meeting simultaneously with those of kindred associations and authorized a participation in planning for another joint meeting in October 1953. The total attendance of registered nurses was 360.

LILLIAN E. PETTIGREW
*Executive Secretary*

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Remoteness of educators from the people they serve will sterilize all efforts to encourage the people to learn about the affairs of the world and their ever-changing environment, And yet we often see men and women in responsible educational positions chasing wills-o'-the-wisp with long names and flighty habits.

What is needed is to put the educational house in order and go on from there to make its influence effective. What do our most thoughtful people—not only educational people but men and women in business, the church, parliament, and in every other sector of life—what do they believe it is most necessary for adults to know? What can be done, within the resources available in Canada, to make the knowledge available? Who can do it best, in each area of information and in each class of student?

Having decided these things, and taken steps to put the plan for real education into motion, it will be time to think of telling people about it.

*—Canadian Association for Adult Education*

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The fight against one of the most common of all diseases, dental caries, has been greatly advanced by clinical proof that the controlled addition of fluoride compounds to public water supplies will reduce incidence of tooth decay by 65 per cent. A 2 per cent solution of sodium fluoride, properly applied to the teeth of children, will reduce tooth decay by 40 per cent. This preventive procedure is of particular benefit to older children who will not obtain the full benefits of fluoridated water.

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When a child loses a first tooth prematurely, the teeth on either side may drift into the space, thus crowding out the second tooth when it arrives. Early loss of baby teeth requires dental care, in order that the permanent tooth may not grow in crooked or misplaced.

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Every day is a Garden where thought flowers grow.
The thoughts that we think are the seed that we sow.
Each kind loving thought bears a kind loving deed,
Each bad selfish thought is like an old weed.
We must watch all our thoughts every hour each day
And pull out the weed thoughts and throw them away.
And plant loving seed thoughts so thick in a row
There will not be room for *weed* thoughts to grow.

—KATHERINE MERRILL

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— ANNA HEMPSTEAD BRANCH

We have no more right to consume happiness without producing it than to consume wealth without producing it.

— GEORGE BERNARD SHAW

# Book Reviews

**An Introduction to Materia Medica and Pharmacology,** by Elsie E. Krug, R.N. and Hugh Alister McGuigan, Ph.D., M.D. 612 pages. McAinsh & Co. Ltd., 1251 Yonge St., Toronto 5. 6th Ed. 1951. Price $4.50.
*Reviewed by Sister Vincent de Paul, Charlottetown Hospital, P.E.I.*

This is an excellent text on pharmacology for the student nurse. The introduction gives a very clear explanation of the terms used in materia medica. This is followed by a chapter on pharmaceutical preparations, in which the various types of medications are defined and illustrated. Many helpful and interesting diagrams and illustrations appear also in other parts of this book. Some chapters are devoted to a review of weights and measures, and pharmaceutical arithmetic.

In the main body of the text, the drugs are very fully discussed in their pharmacological relation to the body. The sections dealing with the newer antibiotics are especially informative. Throughout there are many helpful instructions to the student nurse with regard to the careful use of drugs and their proper administration.

At the end of each chapter, there are questions for review and suggestions for study which should be of great assistance to any student.

At the close, there is an interesting history of materia medica and a chapter on drug legislation.

# 1952 INDEX

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This textbook is deserving of the highest praise, and would be a valuable asset to any nurse's library.

**Handbook of Cardiology for Nurses,** by Walter Modell, M.D. 246 pages. Burns & MacEachern, 165 Elizabeth St., Toronto 2. 1952. Price $4.00.

This book is written because, as the author states, he feels there is now a definite need for a book designed purposely for the nurse who takes care of the cardiac patient. The knowledge of heart disease which the nurse gains from her courses in general medicine, from her experiences with patients, and her contact with physicians is no longer adequate as in the past.

So vital does the author feel is the nurse's contribution, that he devotes his introduction to an explanation of what he means by her role in cardiac cases. The nurse's part is more than the provision of physical care for the patient and includes the equally or even more important tasks of support and reassurance in acute attacks, encouragement and patience in periods of prolonged convalescence, and gaining the confidence of relatives by her knowledge and understanding.

To meet these needs with confidence the nurse must be well informed as to the reasons for the many differences in therapy which she will encounter. This book is of great help along this line.

The sequence of chapters is logical, following through the physical signs, diagnostic aids, specific conditions, and a large section devoted to treatment in which prominence is given to the effects of drugs, including Cortisone and Acth. As one would expect from the author, who is assistant professor, Cornell University Medical School, and associate cardiologist for two large New York hospitals, the information given is based on scientific fact and the opinions expressed are free from bias. A valuable addition is the appendix containing sample menus and lists of foods for a low-sodium diet.

Somewhat less skill has, in my opinion, been shown in the layout of the book than in the excellent content. It would have been improved by clearer divisions of chapters into smaller topics and possibly, for further emphasis, indented section headings. As it is set up now quick reference to any particular topic would require thorough familiarity with the contents.

The author successfully accomplishes his

purpose of helping the nurse more fully to understand the needs of the cardiac patient by writing in an informal narrative style which is easy to read and unburdened by material the nurse cannot use. There are many references to the psychological needs of these patients but more could have been written along these lines without being superfluous.

The book would seem of real value to all nurses, both in curative and preventive fields, but in particular to the nursing arts instructor, to amplify and clarify her teaching of cardiac conditions, and to the nurse who actually cares for cardiac patients, to give her a fuller understanding of her role and deeper job satisfaction.—C.W.P.

**Textbook of Medicine for Nurses.** by J. W. Joule, M.D. 504 pages. H. K. Lewis & Co. Ltd., 136 Gower St., London W.C. 1, England. 1952. Price 30s.
*Reviewed by B. G. Anderson, Clinical Instructor, General Hospital, Moose Jaw, Sask.*

"This book has been written for the student nurse, who, during her training, comes in close contact with a wide variety of diseased conditions and a still greater variety of human beings." Thus the author states his purpose in the preface. He has been most successful in writing a simple, easily understood book of medicine. He has not attempted to cover the whole field. "Many rarer conditions have been omitted to avoid confusing the student nurse."

This is an English text but it is quite applicable to the conditions found in our own country. It is divided into chapters according to body systems, with additional chapters on nutrition, insomnia, bowel action, observations on infectious diseases, including a brief review in microbiology.

A chapter on the more commonly used drugs covers concisely the action, uses, average dosage, and toxic symptoms. Some may consider this chapter superfluous as it is not adequate as a substitute for a pharmacology text.

Nursing care is well outlined, due attention being given to diet, rest, elimination, relief of pain, usual medication and treatment, and special procedures—diagnostic, curative, and supportive. The illustrations are excellent but there could be more of them. The writer tries to impress upon the reader the importance of

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considering not only the disease but also the individual needs of each patient. The factual content of this book seems to compare with that presented by North American authors.

There is a good outline of content at the beginning of the book and an adequate index at the end. The book is well bound, has large easily read print on good quality paper with a rather high gloss.

I feel this book is not as detailed as we require for our students. However, with access to good supplemental and reference texts it could prove of definite value in the education of student nurses.

**Dynamic Psychiatry**, edited by Franz Alexander, M.D. and Helen Ross. 578 pages, J. B. Lippincott Co., Medical Arts Bldg., Montreal 25. 1952. Price $11.00.
*Reviewed by Lois O. Smith, Supervisor, Mental Health Nursing, New Brunswick.*

This book, of multiple authorship, deals ably with dynamic psychiatry—its development, application, and relations with other fields of science and culture. The material is organized into three parts. The 15 contributors are experts in their respective disciplines and the result is an interesting and valuable book.

*Part I*, on concepts of dynamic psychiatry consists of four chapters. The development of the fundamental concepts of psychoanalysis deals with the discovery of the unconscious and psychoanalytical methods of investigation. The author develops the theroy of instincts, goes on to explain the dynamics of ego development, personality development, and psychodynamics of therapy. Dreams and rational behavior explain how dreams serve a problem-solving function. Another author deals with the metaphysical concepts as they are developed in the study of psychoanalysis. Personality Development gives a detailed account of the many factors which go into and influence personality development.

*Part II*, on Clinical psychiatry has seven chapters. Neuroses, behavior disorders, and perversions are discussed, using many histories as illustrations. There is discussion of acute neurotic reactions, considering the incidence, etiology, dynamics of symptom formation, diagnosis, prophylaxis, and treatment. Henry W. Brosin, M.D., has contributed two chapters-the first dealing with the contribution of psychoanalysis to the study of organic cerebral disorders in which he states that the greatest handicaps to progress in this field are: lack of methods and lack of therapists. In his second chapter, dealing with the contribution of psychoanalysis to the study of the psychoses, his hope is for the development of better methods of treatment through research. The psychodynamic approach to the study of psychoses emphasizes the importance of considering each patient as a person. Dr. Levine, in dealing with the principles of psychiatric treatment, states that treatment, based on adequate diagnoses is far superior to that focused merely on symptom relief. He goes on to outline six considerations on which therapy should be based.

*Part III*, the influence of psychoanalysis on allied fields, consists of five chapters. In discussing the psychosomatic approach in medicine it is concluded that knowledge of both psychological and physiological methods is necessary as well as knowledge of personality development; there is no specific technique in psychoanalysis but all such treatment should be individualized. Some relationship between social anthropology and psychiatry is covered by Margaret Mead, Ph.D. She states that anthropology deals with societies while psychiatry deals with trauma. Both recognize patterns which are meaningful and necessary of inter-

pretation. The clinical psychology chapter is concerned with adjustment, with recognition of psychology as a field in its own right, the psychologist one member of the treatment team. The final chapter gives a review of the influence of psychoanalysis on current thought. Freud's thinking is felt extensively and the influence of psychoanalysis on psychology, sociology, anthropology, economics, religion, and literature is discussed briefly.

This book is clear, concise, and thought-provoking, bringing together the most up-to-date material on the subject of dynamic psychiatry and its relationship to the allied sciences. Each chapter is followed by an extensive bibliography which is an excellent guide for those desiring wider knowledge than that contained in the book. This is not a nursing text but nurses interested or engaged in psychiatric nursing would find the book helpful and enlightening.

## Victorian Order of Nurses

THE FOLLOWING are staff changes in the Victorian Order of Nurses for Canada:

**Appointments** — Digby, N.S.: *Jacqueline Connely* (Ottawa Civic Hosp. and University of Western Ontario) as nurse in charge. Montreal: *Frances Nelson* (Vancouver Gen. Hosp.) and *Maria Van Noort* (Hosp. St. Antoniushove, Voorburg, Holland). North York: *Eleanor Morse* (St. Joseph's Hosp., London, and U.W.O.). Ottawa: *Ellen Flannery* (St. Mary's Hosp., Montreal), *Joan Grimes* (Hotel Dieu, Kingston), *Madeleine Martineau* (University of Ottawa School of Nursing) and *Margaret McRae* (Ottawa Civic Hosp.). St. Catharines: *Mrs Betty Farley* (Toronto Gen. Hosp.). Toronto: *Marilyn Chamberlain* (Wellesley Hosp. Toronto), *Alice Chisholm*, *Marilyn Dobbin*, and *Meta McLaughlin* ((all Hosp. for Sick Children, Toronto), *Elisabeth Klein* (University of Toronto School of Nursing), *Merne Powers* (T.G.H.), *Eine Ronty* (Toronto East Gen. Hosp.), *Arky Tanaka* (Portland San. & Hosp., Oregon), and *Ruth Thomson* (Saint John Gen. Hosp., N.B., and U. of T.). Windsor-Hantsport, N.S.: *Geraldine Cochran* (Victoria Gen. Hosp., Halifax).

**Reappointment** — Saskatoon: *Helen Hobbs*.

**SURGERY FOR NURSES**
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**TUBERCULOSIS NURSING**
***by Jessie G. Eyre,***
***St. Helier Hospital, Surrey.***
A valuable guide book for those who wish to specialize in tuberculosis nursing, or to undertake it for post-graduate experience. 303 pages, 103 illustrations, 1949. $5.25.

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**Resignations** — Leamington, Ont.: *Elizabeth Webster* as nurse in charge. Ottawa: *Mrs. Mary Whittle.* St. Catharines: *Mary Marten.* Saint John, N.B.: *Myrna Walker.* Saskatoon: *Mrs. Elizabeth Adair.* Toronto: *Irene Boeke, Audrey Hannah, Mazie MacIntosh, Lyaine Sauve, Jean Steed, Mmes Dorothy Francis, Beatrice Kitzman, Shirley McCory.* Windsor, Ont.: *Helen Hill.* Winnipeg: *Beryl Marsland.* York Township, Ont.: *Dorothy Mizuhara.*

## Nursing Sisters' Association

Nineteen members of the *Charlottetown Unit* were present at the annual dinner meeding held on November 11. At the Memorial Service Mmes Vatcher and Bell placed a wreath for the group. Activities for the past year included making bags for the Canadian Legion gifts to veterans at Christmas and sending cigarettes and magazines to the forces in Korea.

Officers elected for the coming year are: President, M. Haszard; vice-president, V. Darrach; secretary-treasurer, D. MacKenzie. Committee conveners: Visiting, H. MacLaine; ways and means, J. McLean; publicity, B. Smith.

Seventy-six members of the *Ottawa Unit* attended a Remembrance Day dinner at La Touraine Restaurant on November 11 when Elizabeth Smellie, C.B.E., R.R.C., LL.D., was guest speaker. Her talk was entitled "Europe Revisited." Guests at the head table included: Major E. Andrews, R.R.C., Squadron Leader F. Oakes, R.R.C., Agnes Macleod, R.R.C., president, D. Percy, R.R.C.; vice-president, K. Bayley; E. Feasby, E. Bagnall, G. Halpenny, F. Nevins, M. McGuire, M. Kitchen, and A. Fletcher; Mmes H. J. Coghill, E. Wolstein, R. W. Graham, P. J. Philpott, and G. C. Bennett.

# News Notes

## ALBERTA

### CALGARY

The sixth presentation of certificates, caps, and pins to nursing aides took place on October 30 and brought to 1,000 the number of nursing aides to be graduated from the Calgary school. The occasion also marked the last class to graduate from the old school. The new School for Nursing Aides was formally opened by the Hon. A. J. Hooke, Minister of Public Works for the province, following the reception. It is the first school of its kind in Canada.

"We have more nursing aides in training in Alberta than in all the other provinces combined," said the chairman who is regional director of Canadian Vocational Training.

Dr. W. H. Swift, Deputy Minister of Education, outlined the "three s's" in the profession which would help the nursing aide to promote the welfare of her patients. These are skill, sympathy, and a smile.

In his address to the graduates, Dr. A. S. Somerville, Deputy Minister of Health, assured them of a good future in their field. "The training you have had makes you especially suited to bedside nursing . . . you are trained to give a badly needed service in the community—a service in which there will always be a need for nursing aides."

Hon. Dr. W. W. Cross, Minister of Health, said the shortage of nurses in Canada may be blamed on the fact that, within one year of graduation, 60 percent of all R.N.'s are marrying and leaving the profession. He also stated that "in order to alleviate the shortage a greater and greater number of nursing aides will be needed."

The presentation of certificates was made by Dr. M. G. McCallum, director of Hospital and Medical Services, with Isobel Matheson, chief instructor at the school, introducing the candidates. "Teamwork between registered nurses and nursing aides is our aim, said J. Frances Ferguson, R.N., president of the A.A.R.N. and supervisor of training in the province.

The choir of the school sang musical selections and the organist throughout the ceremony was Mrs. P. C. Clarke.

### FRANK

When the nurses of Crow's Nest Pass met at the home of Agnes Margetak, Mrs. J. Bayon of Coleman was appointed secretary to replace C. Harrison of Blairmore who has left to take a position in Regina. The possibility of instituting occupational therapy in the Crow's Nest Pass Municipal Hospital was discussed, while seven local nurses announced they would attend the banquet being held by the Lethbridge nurses.

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LAMONT

*Archer Memorial Hospital*

The annual meeting of the alumnae association was held in November when the following officers were elected: President, Mrs. A. Cowan; vice-presidents, Mmes W. Motyka and A. Strong; secretary-treasurer, Mrs. B. I. Love. To keep members up to date on correspondence, group progress, and activities of other members, there will be an alumnae meeting on the third Monday of every second month—in March, at the home of Mrs. A. P. Southworth, 11018-110th Ave., Edmonton; May, graduation at Lamont; September, Lamont Hospital; November, annual meeting.

Plan for the raising of the $250 scholarship were discussed and the meeting was followed by a turkey supper. The president, Mrs. A. Cowan, welcomed the many alumnae members and husbands, the honorary members, the superintendent of nurses at the hospital, L. M. Young, and the hospital's superintendent, Dr. M. A. R. Young, and his wife. Dr. Young brought to our attention "What the Alumnae Means." The sum of $57 was collected for a local graduate—Ada Sandell—who has been a missionary nurse in Korea for some 24 years. Another interesting feature of the program was the Imperial Oil Co. (Esso) films, shown by Mr. Langford, on the Bahamas and Quebec.

PEACE RIVER

The annual meeting of Peace River Chapter was held at the home of Mrs. H. Thompson when reports on the year's work were presented. Officers were elected as follows: President, Mrs. C. R. Rankin; vice-president, Mrs. H. Thompson; secretary-treasurer, Mrs. B. G. McKenzie; welfare committee, Mrs. M. C. Woodard; executive, Mrs. D. Sproul. E. Peterson.

## BRITISH COLUMBIA

BURNS LAKE

The first annual meeting of the Central Interior District was held in September. Although the district has been functioning for a number of years, this is the first time the chapters have been successful in organizing a meeting, owing to the great distances between the units and the bad road conditions which exist at certain times of the year.

Twenty-eight nurses attended the banquet and the business meeting which followed, while 21 schools of nursing were represented, including schools in England, Portland, Ore., and several provinces. The visitors were welcomed by Mr. Drayson, manager of The Royal Bank of Canada in Burns Lake, and president of the Board of Trade.

C. Preston, who with Mrs. I. Flemming, had been in charge of all local arrangements, served as chairman. Reports were heard from Smithers and Fort George chapters. K. Batchelor gave an account of the R.N.A.B.C. annual meeting in Victoria while D. Munro reported on the C.N.A. biennial convention in

Quebec. Delegates from Smithers included Miss Batchelor, Mmes MacDonald and I. Pierce, Srs. M. Noemi and M. Winnifred.

The following officers were elected to serve during the coming months: President, Mrs. R. Richmond; vice-president, Mrs. J. MacDonald; secretary, Mrs. W. Warner; treasurer, K. Batchelor; councillor, S. Bradford.

The next annual meeting is scheduled for September at Burns Lake.

### CLOVERDALE

The South Fraser Chapter held their election of officers in November, the result being as follows: President, Mrs. D. Slaughter; vice-presidents, K. Ross, Mrs. F. D. Sinclair; secretary, Mrs. F. Gladstone; treasurer, Mrs. J. Keays. Conveners: Membership, T. Arngrimson; program, D. Morris; social, Mrs. A. Hepple; *The Canadian Nurse*, Mrs. K. Grieve. The past president is Mrs. L. Hughes.

### MERRITT

Mrs. Alice Manson has been appointed matron of Nicola Valley General Hospital. She was formerly day supervisor at Royal Inland Hospital, Kamloops.

### NELSON

Regular meetings of Nelson Chapter have dealt with the C.N.A. Structure Study, rummage sale, and Christmas parties. A committee is being appointed to consider and report on the Study. At the October meeting, D. Dove of the Provincial Laboratory, gave an interesting talk and showed slides concerning their work. In November the members heard Mr. R. Arnold of Abbott Laboratories Ltd. who lectured on "Antibiotics." The chapter awarded two $100-bursaries to Nelson girls who desired to take up nursing. M. Chambers and J. Fornelli are now both in training as a result of the chapter's action.

The staff at Kootenay Lake General Hospital now includes: M. Davies, superintendent, replacing M. Whitmore; J. Hood, C. Drew, O. Golib, M. Parker.

### PRINCE GEORGE

A refresher course of nine lectures in connection with the Civil Defence program for registered nurses, was resumed in September at the local hospital. Sponsored by the Fort George Chapter, Dr. J. G. McKenzie opened the series with a lecture on obstetrics, centred around emergency deliveries.

### PRINCE RUPERT

A joint meeting of Prince Rupert and Miller Bay chapters was held at the General Hospital when Mrs. E. L. Bartlett, president, was in the chair. At this well attended gathering, Doris Hallt, assistant matron at Miller Bay Hospital, reported on the C.N.A. biennial convention in

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● Candidates must be British subjects, under 40 years of age, except in the case of ex-service women who are given preference. Application Forms obtainable from all **Government Agencies, the Civil Service Commission, Weiler Bldg., Victoria,** or **636 Burrard St., Vancouver 1,** to be completed & returned to the

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Quebec. Mr. D. Stevenson, General Hospital administrator, told of some of the legal problems involved in nursing, referring to the differences in registration in Canada and stressing the advantages to the nurse of registering in the province in which she is practising her profession.

## TRAIL

Members of Trail Chapter have reaffirmed, by a donation, their support of the Kootenay Society for Handicapped Children now in operation in Trail. V. B. Eidt, superintendent, Trail-Tadanac Hospital, has been appointed a representative on the R.N.A.B.C. Legislation Committee. Nurses have several enthusiastic curling teams on the ice again and are looking forward to many happy times.

A course of lectures for nurses on surgical nursing is being given by the C. S. Williams Clinic in Trail. The subject of Fluid Balance in the Surgical Patient was discussed by Drs. A. F. Alvarez and J. D. Hare to initiate the series. Further topics to be covered include: Shock and trauma; burns; head injuries; major surgical abdominal conditions; surgical thoracic cases.

## VANCOUVER

### *St. Paul's Hospital*

The annual event of the alumnae, the "Homecoming"—was a great success. A special "thank you" is extended to the convener, Mrs. D. Cowper, Mmes Collishaw and D. MacKenzie, and to the Sisters for their help in various capacities, as well as to every nurse who helped to make this a delightful occasion. Special guests were members of the 1914 class, including: C. McGovern Mrs. F. Barry, Dulcie (Martin) Preston, and Sr. Stephonia. Over 250 nurses sat down to a hot turkey dinner. Many came from outlying points such as: Whitehorse, Portland, Burlington, Wash., Blairmore, Alta., Revelstoke, Nelson, and many points on Vancouver Island.

Mrs. Dawe gave a brief outline of the history of the hospital and of the life of Dorothy Fripp, founder of the alumnae. Mrs. Murray, the president, was M. C. of the festivities, ably assisted by Sr. Columkille. Mrs. Mowatt was the lucky winner of the door prize.

There are now 2,000 graduates of St. Paul's scattered throughout the world but on October 7, 1952, only 103 *active* (meaning having paid $2.00 yearly dues) members. To become a member in good standing and to receive *The Bulletin* regularly sent your $2.00-bill to *Mrs. M. Banner, Treasurer, St. Paul's Hospital Alumnae Association, 1056 Comox St., Vancouver 5, B.C.*

At the September alumnae meeting Sybil Ingalls gave on talk on "The Growth of the Emergency Department in St. Paul's Hospital."

Alice Whiteworth, formerly matron at Port Alice Hospital, has left for Honolulu and England and thence around the world. M. Melnyk is at St. Luke's Hospital, Bellingham.

## NEW BRUNSWICK

### FREDERICTON

Edna Felsing, newly appointed director of nurses at Victoria Public Hospital, was welcomed at a fall meeting of Fredericton Chapter. The president, Mrs. M. M. Scott, stated that Miss Felsing needed no formal introduction as she was already known to many, being a V.P.H. graduate and a former chapter member. A special guest was the N.B.A.R.N. vice-president, Grace Stevens of Edmundston.

Routine business included a discussion on the financing of the nurses' registry and the Structure Study, the latter to be the chapter's project for the coming months. "Highlights of the Quebec Biennial" took the form of a panel discussion. Those participating included: I. Lane, adviser to the schools of nursing in the province; D. Grieves, V.P.H. instructor of nurses; V. Burchill, polio clinic charge nurse; and Mrs. R. Crewdson, V.P.H. staff member. Films were also shown of Quebec and Montreal.

### MONCTON

Mrs. Nash Smith was elected president of Moncton Chapter at the annual meeting held in November. The vice-presidents are Mrs. F. Carroll and H. Hayes. Mrs. I. MacKenzie will serve as secretary, with Mrs. M. Wilbur acting as treasurer. Additional executive members include: F. Northrup, R. MacKenzie, M. Tait, L. Good, S. MacLeod, and F. Eagles; Mmes J. Coates, M. Robinson, V. Brand, J. Innes, A. Allain, G. Shaw, R. Cormier, and J. Lutes.

At a previous monthly meeting various committee reports were read, including an account of the successful cooking and fancy-work sale.

## NOVA SCOTIA

### HALIFAX

*Halifax Infirmary*

At the opening meeting of the reunion of the alumnae association held in October, two life memberships in the association were presented—one to Mrs. John Purcell, a member of the first graduation class in 1911, and the other to Sr. Marie Aloysia, nurse in charge of students' health at St. Joseph's Orphanage, who has nursed the longest number of years. Mrs. C. Joncas, alumnae president, Rev. D Campbell, and Mayor R. A. Donahoe participated in this memorable event.

## ONTARIO

### DISTRICT 1

### CHATHAM

*Public General Hospital*

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when Mrs. Kate Aitken was guest speaker. Class reunions were held in the afternoon and approximately 150 graduates attended the banquet. A bake sale was planned for December.

The following officers will serve during the coming months: Honorary president, P. Campbell; president, Mrs. R. Judd; vice-presidents, Mrs. R. Brown, M. Cochrane; recording secretary, M. Case; corresponding secretary, Mrs. K Brisley, assisted by B. Stenton; treasurer, Mrs. M. Case. Councillors, Misses V. Dyer, Tinney, M. McNaughton, D. Thomas. The historian is L. Hastings.

## District 2

### Stratford

The Board of Directors of the Community Nursing Registry held a quarterly meeting in September at the General Hospital with Mrs. C. Walkom, president, in the chair. A financial report and registry work report was given by Mrs. W. J. Byrick, registrar. Mrs. E. Taylor read the credential committee statement and Mrs. E. Stoskopf revealed that speakers had been arranged for the educational program and it was hoped that many nurses would take advantage of this series of lectures. It was learned that approximately one-half of the $1,000 needed according to the 1952 budget had been raised at the program held last June in the Classic City Arena.

Mrs. Stoskopf was appointed as delegate to the District 2 annual meeting in Simcoe. Mrs. Byrick, representative to the Civil Defence Planning and Advisory Committee, gave a report of the meeting attended and progress made by the Civil Defence organization.

## District 3

### Orangeville

The first annual meeting of District 3 was held in October with W. M. Cooke, director of nurses at General and Marine Hospital, Owen Sound, and district chairman, presiding. The address of welcome was given by Mayor W. Richardson and greetings were received from Dr. C. I. Scott, Medical Society president. Reports were heard and in the afternoon Mr. Murray McKitrick spoke on "Words—One of Woman's Greatest Weapons." The speaker at the dinner was Rev. J. Bartlett.

### Guelph

A dinner at Royal Hotel marked the first meeting of industrial nurses of the district when several centres were represented, including Georgetown, Guelph. Galt, and Kitchener. Special guests were Drs. C. Pinch and J. R. Loudoun, and Misses J. Elliott, D. Jackson, and M. Allan, preliminary students from the Guelph General Hospital. Dr. Pinch was the evening's speaker and, during the course of his

lecture, he made reference to the large scope of opportunities for nurses in industry. He felt that a nurse is in a position to promote good worker relationships and spot industrial hazards. The three students from the hospital entertained the gathering with duets and a solo.

A visit to the health centre at the Federal Wire and Cable Co. Ltd. closed the meeting.

## District 6

### Port Hope

M. Millard of Belleville was elected chairman of District 6 at the annual meeting. She succeeds H. McGeary, nurse in charge of the V.O.N. in Peterborough. The remaining members of the executive are: Vice-chairmen, R. Cunningham, M. Waters, J. Findley; secretary-treasurer, I. Sine. Representatives: Private nursing, Mrs. S. Prentice; public health, V. Clarke; institutional nursing, M. Mill; industrial nursing, M. Greer. Committee conveners: Membership, V. Nelson; nominating, V. O'Leary.

## District 7

### Kingston

At a meeting of Kingston Chapter attended by 40 members the guest speaker was Edith Fenton, R.N.A.O. public relations secretary. She gave some helpful suggestions on ways and means to increase membership, one of which would be to include the entire county in the local chapter. Mr. McCarthy, chapter chairman, presided. Refreshments were served in the Ann Baillie Nurses' Home of the General Hospital, locale of the meeting.

### *Ontario Hospital*

At a meeting of the alumnae association, the members viewed a film entitled "Vitamins and Some Deficiency Diseases." Examples of diseases caused from lack of vitamins were portrayed, along with methods of prevention and treatment. Mrs. A. Kennedy was chosen as convener for the Christmas dinner, assisted by Mmes M. Bernasconi and A. E. Peters. Reference was also make to the forthcoming course in A.B.C. Warfare to be held at the hospital. A delicious lunch was served by M. Hollingsworth and assistants.

## District 10

### Port Arthur

Seventy members were present at a meeting of District 10, including several new graduates and nurses from Great Britain. Out-of-town members present were Mmes Cox and Stewart from Dryden. Sr. Patricia, chairman, presided, and reported that the total membership is now 267. A. Malmborg, in her capacity as *Canadian*

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*Nurse* representative, said that nine subscriptions has been forwarded to the *Journal* office. D. Adams gave an account of the activities of the Public Health Nursing Committee. Reports were submitted by K. Feisel, Miss Pothier, and Sr. Patricia on the C.N.A. biennial convention in Quebec. Sr. Patricia told the members that she had attended the R.N.A.O. Board of Directors' meeting in Toronto when Dr. MacKinnon Phillips was present, several items of interest to the nursing profession having been discussed.

## DISTRICT 11

### BURKS FALLS

Bernice Kent is now nurse in charge at the Red Cross Hospital, succeeding R. McDiarmid who has held this position for the past three years. Miss McDiarmid is now at Beardmore. Miss Kent, a native of Drumbo, near Woodstock, is a graduate of the Brantford General Hospital. Before her new appointment, she was in charge of hospitals at Richard's Landing, Atikokan, and Hornepayne.

## PRINCE EDWARD ISLAND

A most enjoyable meeting was held at the summer home of Mr. and Mrs. A. Kelly at Rosebank last August by the members of St. Veronica's Guild. The meeting was opened with prayer by Rev. Alex MacLellan, C.Ss.R. chaplain. At the business session plans were discussed for the furnishing of the playroom in the new pediatric department of Charlottetown Hospital. M. Mitchell and D. McInnis were named as nominating committee for the annual meeting. At the conclusion of business, an auction sale of home-cooking, groceries, candy, etc., was conducted by Mrs. Maddigan, adding considerably to the Guild funds.

The following nurses are taking post-graduate courses: Dalhousie University, Halifax—C. Gordon and J. McGaughy (public health); Kentville Sanatorium, N.S.: E. MacDonald and D. White (tuberculosis nursing), who will be returning to Provincial Sanatorium, Charlottetown; McGill School for Graduate Nurses—B. Delaney (clinical supervision in obstetrics); University of Toronto School of Nursing—D. Cox (second year of public health nursing degree course) and F. K. MacLean (teaching and supervision in schools of nursing).

## SASKATCHEWAN

### SASKATOON

### *St. Paul's Hospital*

In accordance with the real Christmas spirit, the alumni sent cans of milk and soup for the Indian children at the Grey Nun's mission. This enabled the little ones to enjoy a lunch between meals.

Sr. Bezaire, Sr. Ste. Croix, Sr. Quintal, Misses Mackenzie and Brkich, and Mrs. Howe represented the hospital at a Nursing Education Institute held in Regina in November. M. Keyes of the Canadian Psychiatric Society was an honored visitor to the school. A series of talks on Public Speaking is being given to third-year students by J. LeGars. F. McDonald, educational director, has resigned to go back home to Edmonton.

# Positions Vacant

*Advertising Rates—$5.00 for 3 lines or less; $1.00 for each additional line.*

**Clinical Instructor (Psychiatric Nursing).** Salary: $248-298 per mo. **General & Psychiatric & General Graduate Nurses.** Salary: $198-248 per mo. Salaries depend on qualifications & experience. 44-hr. work wk. Uniforms supplied. Modern residence. $30 charge per mo. for perquisites. Excellent holiday, sick leave & pension benefits. Apply, stating qualifications & experience, Supt. of Nurses, Provincial Mental Hospital, Ponoka, Alta.

**Head Nurse for Operating Room,** B.C. Civil Service — Tranquille Sanatorium (Division of T.B. Control, Dept. of Health). Salary: $245 rising to $271 per mo. Registered Nurse. Experience & supervisory ability in the specialty. Attractive location. Living quarters & meals available at nominal rates. For information & application forms, write Director of Nursing, Division of T.B. Control, 2647 Willow St., Vancouver 9, or B.C. Civil Service Commission, 636 Burrard St., Vancouver 1, B.C.

**Head Nurse — Nursery & Delivery Room.** Experienced. Beginning salary: $13.50 day; $14.50 afternoon & night. Desirable personnel policies. 45 min. from Detroit, 3 miles from Selfridge Air Force Base. Apply Director of Nursing, St. Joseph Hospital, Mt. Clemens, Michigan.

**Public Health Nurse** (qualified) for Sanatorium in Préfontaine, Que., in the Laurentians. Must have T.B. experience. Bilingual preferred. Week is divided with 2 days at Sanatorium, 2 days doing field in Montreal, and 1 day for organization, statistics & records. Write Mrs. H. M. Ripstein, Apt. 303, 5025 MacDonald Ave., Montreal 29, Que. **(Phone WAlnut 7875).**

**Registered Nurses (2)** immediately for new 30-bed hospital. Salary: $180 plus maintenance. 48-hr. wk. 3 wks. vacation plus statutory holidays. Apply Matron, Union Hospital, Balcarres, Sask.

**Hospital Supt.**—Registered Nurse with hospital administration experience for 50-bed hospital with Training School. Full maintenance, vacation with pay & sick leave. Apply Chairman, Board of Trustees, Carleton Memorial Hospital, Woodstock, N.B.

**Supt. of Nurses** for 50-bed hospital. Must be well qualified person. Salary open. Apply stating qualifications, experience & reference, Administrator, Wrinch Memorial Hospital, Hazelton, B.C.

**Administrative Asst. of Nursing Service.** Salary: $15 per day for qualified person. Desirable personnel policies. 45 min. from Detroit, 3 miles from Selfridge air force base. Apply Director of Nursing, St. Joseph Hospital, Mt. Clemens, Michigan.

**Asst. Director of Nurses & General Duty Nurses.** Apply Director of Nurses, Royal Inland Hospital, Kamloops, B.C.

**Matron (1) & Nurse (1)** for Union Hospital, Lucky Lake, Sask. Salaries: $225 & $180 plus maintenance, respectively. Apply G. D. Clark, Sec.-Treas., Lucky Lake, Sask.

**Instructor** (qualified) to begin duties July 1, 1953. Salary: $240 gross. **General Staff Nurses** for medical, surgical & obstetrical floors. Salary: $180-195. gross depending on experience. 44-hr. wk. 2½ days holidays per mo. Half day on statutory holidays. 1½ sick days per mo. cumulative to 30 days. $30 charge for board & room. 177-bed hospital with Training School. Apply Mrs. M. Alexander, Acting Director of Nurses, General Hospital, Medicine Hat, Alta.

**Science & Nursing Arts Instructors** (one of each). New hospital to open early in 1953 Salary open. Apply Supt. Charlotte County Hospital, St. Stephen, N.B.

**Junior Instructor** (qualified) immediately to teach Nursing Arts. One class of students per yr. Salary: $215 increasing to $235. Room in residence available at $10 per mo. if desired. Good personnel policies. Apply Director of Nurses, General Hospital, Guelph, Ont.

**Operating Room Supervisor** (special preparation preferred). Also **Dietitian & Night Supervisor** for 100-bed hospital. Salary depends on qualifications & experience. Apply Soldiers' Memorial Hospital, Campbellton, N.B.

**Operating Room Nurses** for Victoria General Hospital, Halifax, N.S. For details apply Director of Nurses.

**Head Nurse** for 30-bed Pediatric Unit in 100-bed Children's Hospital. All-graduate staff. Experience in charge work as well as pediatric knowledge essential. R.N.A.B.C. recommendations. For further information apply Director of Nursing, Children's Hospital, 250 W. 59th Ave., Vancouver 15, B.C.

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**Head Nurse**—Surgical Floor & Medical Floor. Experienced. Beginning salary: $13.50 day, $14.50 afternoon & night. Desirable personnel policies. Hospital 20 miles from Detroit, 3 miles from Selfridge Air Force Base. Apply Director of Nursing, St. Joseph Hospital, Mt. Clemens, Michigan.

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**Operating Room & Maternity Nurses.** Salary: $162.50 for recent graduates. Two meals, laundry. 8-hr. day—straight shift. $15 differential evenings—$10 nights. Vacation, sick time & statutory holidays on salary. Semi-annual & annual increments. Financial recognition for years of experience, post-graduate or university study. Apply Supt. of Nurses, General Hospital, Winnipeg, Man.

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**Dietitian** for 50-bed hospital with extension opening first of 1953. Apply, stating qualifications, salary expected, etc., Supt., The Cottage Hospital, Pembroke, Ont.

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**Asst. Dietitian** (qualified) for 225-bed hospital. Apply Chief Dietitian, Moncton Hospital, Moncton, N.B.

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**General Duty Nurses** for 430-bed hospital. 44-hr. wk. 11 statutory holidays. Salary: $215-253. Credit for past experience. Annual increments. Cumulative sick leave. 28 days annual vacation. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

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**General Duty Nurses** for modern 50-bed hospital. Gross salary: $215 less $40 board & lodging. $10 annual increase. 10 statutory holidays. 4 wks. annual vacation. 1½ days sick leave per mo. cumulating to 36 days. Transportation allowance not exceeding $60 refunded after 1st yr. Apply Administrator. Wrinch Memorial Hospital, Hazelton, B.C.

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**Graduate Floor Duty Nurses** for General Hospital, Hamilton, Ont. Gross initial bi-weekly salary: $83 plus Cost of Living Bonus of approx. $6.00 per wk. 44-hr. wk. For other perquisites & further information apply C. E. Brewster, Supt. of Nurses.

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**Graduate Floor Duty Nurses** for Mount Hamilton Maternity Hospital, Hamilton, Ont. 44-hr. wk. Statutory holidays. Initial gross salary bi-weekly: $83 plus cost of Living Bonus. For other perquisites & further information apply Supt.

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**General Duty Nurses.** Salary: $173.23 (one hundred seventy-three dollars & twenty-three cents) monthly, paid on a bi-weekly basis; 26 pays in a yr. Salaries have scheduled rate of increase. 48-hr. wk. 8-hr. broken day: 3-11, 11-7, rotation. Cumulative sick leave. Pension Plan in force. Blue Cross. 3 wks. vacation after 1 yr. service. Apply Supt. of Nurses, Muskoka Hospital, Gravenhurst, Ont.

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**General Duty Nurses** for 611-bed General Hospital with School of Nursing. Salary: $273; increase $15 end of 1st yr.; $17 end 2nd & 3rd yr.; $19 end 5th yr. Differential of $10 for special services & p.m. & night duty. 40-hr. wk. 12 paid holidays. 3 wks. vacation. Free laundry. Cumulative sick leave. Housing available. Apply Director of Nursing Service, General Hospital, Fresno, California.

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**General Duty Nurses** for large General Hospital. Openings available in all depts., including pediatrics & isolation, for nurses interested in permanent positions. Apply Director of Nursing, Victoria Hospital, London, Ont.

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**Graduate Nurses** for modern well equipped Teaching Hospital in Central California. Salary: 273-320 per mo. 40-hr., 5-day wk. Liberal vacation. Holiday & sick leave plan Apply Personnel Office, 510 E. Market St., Stockton, California.

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**Registered Nurses** for General Duty in busy 70-bed General Hospital. Commencing salary: $180 per mo. for 44-hr. wk. Good personnel policy. Apply Supt., Ross Memorial Hospital, Lindsay, Ont.

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**Registered Nurses for General Duty** for small General Hospital. Salary: $140 per mo. with full maintenance. 6-day wk. 8-hr. duty, rotating shifts. 3 increments of $5.00 per mo. at 6-mo. intervals. Blue Cross paid. 10 days sick leave per yr. 6 statutory holidays. 28 days holiday. Apply Lady Supt., Barrie Memorial Hospital, Ormstown, Que.

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**Registered Nurses for** St. Joseph Hospital, Mt. Clemens, Michigan, 25 miles north of Detroit, near Selfridge Air Force Base. Optional 40- or 44-hr. wk. **Staff Nurses:** $12 day duty; $13 afternoon or night duty. State Standards. Apply Director of Nursing Service.

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# WANTED

## OPERATING ROOM SUPERVISOR

The *Victoria Hospital* in *London, Ontario,* has an opening for a trained and experienced **Operating Room Supervisor** for an active Surgical Department.

- **EXCELLENT PERSONNEL POLICIES**
- **GOOD SALARY**

*Apply* — **DIRECTOR OF NURSING, VICTORIA HOSPITAL, LONDON, ONT.**

**Registered Nurses** with Public Health training & experience, preferably generalized Not over 35 yrs. of age. Initial salary: $2,700 with annual increment. Pension scheme available. Apply Director, Nursing Service, Ontario Society for Crippled Children, 92 College St., Toronto 2, Ont.

**Registered Nurses for General Duty Staff.** Salary commences at £37-10-0 per mo. with full maintenance. Transportation allowance. For full particulars apply Matron, King Edward VII Memorial Hospital, Bermuda.

**Graduate Nurses for General Staff Duty** in 350-bed Tuberculosis Hospital. For further information apply Director of Nursing, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, Que.

**General Duty Nurses (3).** Commencing salary: $220; full maintenance $45 per mo. 44-hr. wk. 28 days annual leave plus 10 statutory holidays. Annual increases & sick leave. Fare advanced if desired. Apply Director of Nursing, General Hospital, Princeton, B.C.

**Graduate Nurses** for completely modern West Coast hospital. Salary: $230 per mo. less $40 for board, residence, laundry. $10 annual increments. Special bonus of $10 per mo. for night duty. 1 mo. vacation with full salary after 1 yr. service. 1½ days sick leave per mo. cumulative to 36 days. Transportation allowance not exceeding $60 refunded after 1st yr. Also **O.R. Supervisor.** Salary: $270 per mo. Working conditions & perquisites same as nurses. Apply, stating experience, Miss E. L. Clement, Supt. of Nurses, General Hospital, Prince Rupert, B.C.

**General Duty Nurse** for small well equipped hospital. 8-hr. day, 5½-day wk—rotating shifts. Long week-end following night duty. Salary: $150 plus full maintenance. $5.00 increase after 1 yr. 1 mo. vacation after 1 yr. Appy Supt., Saugeen Memorial Hospital, Southampton, Ont.

**Nurses (2).** Salary: $180 per mo. with full maintenance. Modern nurses' home. Usual holidays with pay, sick leave, etc. Transportation one way refunded if stay 1 yr. Apply Matron, Union Hospital, Vanguard, Sask.

**Director of Nurses** for modern 100-bed General Hospital in Southern Ontario. Attractive suite available in nurses' residence. Salary according to qualifications. Apply Supt., Tillsonburg District Memorial Hospital, Tillsonburg, Ont.

**Asst. Director immediately.** Charge of educational program. Basic diploma course. 150 students. 360-bed General Hospital. 15-min. drive from heart of Cincinnati, Ohio. Salary: $350. 40-hr. wk. 4 wks. annual vacation. Degree required. Roman Catholic preferred. Experience considered. Apply c/o Box F, The Canadian Nurse, Ste. 522, 1538 Sherbrooke St. W., Montreal 25, Que.

**General Duty Nurses.** Positions open 30 miles from New York City. Salary: $210-220 for 40-hr. wk., 8-hr. day 3 wks. vacation. 7 paid holidays. 12 days sick leave. Also **Operating Room Nurses** at higher salaries. Apply Administrator, Ossining Hospital, Ossining-on-Hudson, New York.

**General Duty Nurses** for Obstetrical, Medical & Surgical Depts. Living-in accommodation available temporarily. For information apply Director of Nurses, General Hospital, Woodstock, Ont.

# NURSES WANTED

The **Indian Health Services** of the **Department of National Health & Welfare** require **Registered Nurses & Licensed Practical Nurses** for Hospital, fully modern Outpost Nursing Stations & Public Health Nursing positions.

*Beginning Salaries*—**Registered Nurses**, $2,300-2,720. **Licensed Practical Nurses** with 2 yrs. experience, $1,920-2,220. 44-hr. wk. 3 wks. leave with pay annually plus additional 12 days leave with pay in isolated areas. Educational opportunities.

*Apply:*

**522 Dominion Public Bldg., Winnipeg, Manitoba** (Telephone: 927-100)

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**Nursing Arts Instructor; Supervisor & Clinical Instructor — Medicine; Supervisor & Clinical Instructor — Surgery; Supervisor & Clinical Instructor — Gynecology.** All positions open now at School of Nursing, General Hospital, Hamilton, Ont. Address applications & requests for further information to Director of Nursing.

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**General Duty Nurses** for Medical-Surgical Services & Obstetrics. 44-hr. wk. Blue Cross Plan available. Cumulative sick time. For further information apply Director of Nursing, General Hospital, Belleville, Ont.

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**Operating Room Supervisor** with post-graduate experience and **General Staff Nurses** for 80-bed hospital. For full particulars apply Director of Nursing, Norfolk General Hospital, Simcoe, Ont.

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**Graduate Nurses for General Duty & Operating Room** immediately for new modern hospital just opened. Makes for ideal working conditions. Present starting salary for B.C. registration: $215 gross. R.N.A.B.C. working agreement. Contract for 1953 being negotiated. Apply Supt. of Nurses, West Coast Hospital, Port Alberni, B.C.

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**Graduate Nurses (1 or 2)** for 12-bed hospital, 16 miles from Banff, Alberta, Salary: $172.50 less $22.50 room & board. Statutory holidays. 1 mo. holiday after 1 yr. $5.00 increments every 6 mos. Rotating shifts. Apply Matron, Canmore Hospital, Canmore, Alta.

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**Asst. Director of Nursing** for 600-bed Tuberculosis Hospital. Apply Director of Nursing, Beck Memorial Sanatorium, London, Ont.

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**Municipal Nurses** for the Province of Alberta. Rural service, emergency treatment, preventive & maternity program. Salary: $2,160-3,000 depending on qualifications & experience, plus modern furnished cottage. Excellent sick leave, pension & vacation benefits. Apply Director, Nursing Division, Dept. of Public Health, Administration Bldg., Edmonton, Alta.

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**Supt. (1) & Nurse (1)** for 14-bed hospital — modernly equipped, pleasantly situated. Salaries: $150 & $110 per mo. clear. 1 mo. vacation annually. Apply Supt., Grand Manan Hospital, Grand Manan Island, New Brunswick.

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**Obstetrical Supervisor** for new Maternity Wing. Initial salary: $180 per mo. plus maintenance. **General Staff Nurses** for all depts. Salary: $150 per mo. with maintenance. Apply Supt., Soldiers' Memorial Hospital, Orillia, Ont.

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**Obstetrical Supervisor** with special preparation. Gross minimum salary: $240 — annual increments. Vacation, sick time. 48-hr. wk. For further details apply Supt. of Nurses, General Hospital, Moose Jaw, Sask.

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**Supervisor — Obstetrics.** Must have advanced preparation & experience. Teaching program for expanding General Hospital. 8-hr. day, 6-day wk. 1 mo. vacation after 1 yr. 12 days sick leave after 6 mos. Blue Cross insurance. Laundry & maintenance. Salary commensurate with position. Apply Director of Nurses, St. Andrews Hospital, Midland, Ont.

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## ● VANCOUVER GENERAL HOSPITAL ●

● The Vancouver General Hospital invites immediate enquiries from *Graduate Nurses for Staff Vacancies* in order to implement 40-hour week.

SALARIES of $226.50 as minimum and $263.25 as maximum, plus shift differentials for Evening and Night Duty approved for 1953.

*Please apply to:*

**Personnel Dept., General Hospital, Vancouver 9, B.C.**

*Applications should be accompanied by letter of acceptance of registration in B.C. from* ***Registrar of Nurses, 1101 Vancouver Block, Vancouver 2, B.C.***

**Psychiatric Administrative & Teaching Supervisor** for large Psychiatric Hospital. Salary: $180 with full maintenance or $220 if living out. 42-hr. wk. — straight shift. 30 days Vacation after 1 yr. service 2 wks. sick leave per yr. 9 statutory holidays. Teaching certificate, psychiatric experience & eligibility for Quebec licence required. Apply Director of Nursing, Box 6034, Montreal, Que.

**O.R. Scrub Nurse & Supervisor** to have complete charge of organizing & setting up of O.R. procedures. Also **General Duty Nurses.** For active 60-bed General Hospital in Western Ontario town with pop. of 4,000. Situated 25 miles from London with good bus or train service. Apply, stating experience, year of graduation, P.G. course if any & salary expected, Supt., General Hospital, Strathroy, Ont. (Phone collect *Strathroy 865*).

**Dietitian** for Fort William Sanatorium, Fort William, Ont. 320 beds. Salary: $300 with deduction of $38 for full maintenance if well qualified. Apply Medical Supt.

**Public Health Nurse** (qualified) immediately for City of Ottawa Health Dept. Salary range: $2,280-2,640 plus generous Cost of Living Bonus. Generalized public health nursing program. Good personnel policies. 3 wks. vacation annually. Superannuation & Blue Cross benefits. Apply Dr. J. J. Day, Medical Officer of Health, Transportation Bldg., 48 Rideau St., Ottawa 2, Ont.

## Mental Hygiene Institute

The School of Nursing, Dalhousie University, announces a three-day Institute on Mental Hygiene to be held on *February 11, 12, and 13,* in the Arts and Administration Building, Studley Campus. Miss Elsie Ogilvie, R.N., formerly of the School for Graduate Nurses, McGill University, now Nursing Consultant, American Psychiatric Association, will be the guest speaker. Dr. R. O. Jones and members of the Department of Psychiatry, Dalhousie University, will participate in the program. An invitation is extended particularly to nurses in the Atlantic Provinces but all are welcome. For further details write to **Director, School of Nursing, Dalhousie University, Halifax, N.S.**

## Workshop at McMaster

A workshop on **Science in the Curriculum** for science instructors, nursing arts instructors, and clinical supervisors is scheduled for *May 26 to 30,* inclusive, at the ***McMaster University School of Nursing, Hamilton, Ont.*** The leader will be Miss LaVerne Thompson, R.N., M.A., M.S., assistant professor of nursing education, Teachers College, Columbia University. The enrolment is limited to 25, with preference given to science instructors. The registration fee is $25 and residence accommodation will be available. *Course will be withdrawn if sufficient applications are not received by* **April 30.**

Apply to the DIRECTOR OF NURSING EDUCATION at the University.

## CANADIAN RED CROSS SOCIETY

invites applications for ADMINISTRATIVE and STAFF positions in HOSPITAL, PUBLIC HEALTH NURSING SERVICES, and BLOOD TRANSFUSION SERVICE for various parts of Canada.

- The majority of opportunities are in OUTPOST SERVICES in British Columbia, Saskatchewan, Manitoba, Ontario, Quebec, New Brunswick, and Nova Scotia.
- Commensurate salaries for experience and qualifications. Transportation arrangements under certain circumstances. Bursaries are available for post-graduate study.

*For further particulars apply:*

NATIONAL DIRECTOR, NURSING SERVICES, CANADIAN RED CROSS SOCIETY,
95 WELLESLEY ST., TORONTO 5, ONTARIO.

## Preliminary Class Commencing

The ***School of Nursing, St. Joseph's General Hospital, North Bay, Ontario,*** will be commencing a Preliminary Class on February 3. For particulars write to the Supt. of Nurses.

**Clinical Supervisor** (qualified) for The Victoria Public Hospital, Fredericton, N.B. For details apply Director of Nurses.

**Registered Nurses** for supervisory positions & staff nursing for new & beautifully equipped 100-bed hospital in Oregon, U.S.A. Excellent salaries & 40-hr. wk. Apply Director of Nurses, County General Hospital, Tillamook, Oregon.

**General Duty Nurse** for 107-bed modern hospital. Starting salary: $165 per mo. plus meals & laundry. Additional for each evening or night shift. Increases at 6 mos. & annually thereafter for further 2 yrs. 44-hr. wk. 8 statutory holidays. 21 days holiday with pay. Travelling expenses refunded after 6 mos. from point of entry into Ont. Cumulative sick time. Medical & hospital plan subsidized. Apply Supt. of Nurses, Kirkland & District Hospital, Kirkland Lake, Ont.


## Tolerance

The tolerant person is too often thought of as one who is merely easy-going and indifferent to the affairs and opinions of others. That, of course, is not consistent with the original meaning of the word which is from the Latin, *tolero* — to endure or put up with. Different, indeed, from our usual interpretation of the word! To show tolerance is to think so much of others that we recognize their right to think and act differently from ourselves. In fact, the more deeply we hold convictions, the more we realize that only by freedom of thought have we come to a secure place and we can then more easily practise true tolerance by helping to make conditions such that there is real freedom of thought, speech, and action for all. Even though this is sometimes grossly abused, yet it is only by this way of thinking things through for ourselves, and by acknowledging the right of others to do the same, that we can come to full adulthood. Freedom of thought need not mean isolation or that we cannot benefit by the experience and wisdom of others: indeed we should be most unwise not to do so but we do not need to accept or reject any idea or philosophy blindly. Rather should we give to each the consideration it deserves.

The intolerant are usually those people who are afraid that their own particular way of life or religion will not stand the test of investigation and criticism from those

**ANESTHESIA**

A career specialty for the Graduate Nurse. **Eligibility:** Graduates of Accredited Schools of Nursing. **Course:** Study of the basic sciences related to Anesthesia. Clinical training in all phases of General Anesthesia, Resuscitation, and Inhalation Therapy. **Professional Opportunities:** Full-time position in teaching and non-teaching hospitals in United States. For special course write: **Mary H. Snively, R.N., In Charge of Nurses' Training Programs, Duke Hospital, Durham, North Carolina.**

who are likely to oppose it. Almost always fear is at the root of intolerance and bigotry.

The truly tolerant person, on the other hand, standing firm on a rock of tried truth, is not only content but, indeed, anxious for others to examine and probe the various ways of life, believing that patient and completely honest searching will bring truth. Such a person, broad in mind, imaginative in understanding, secure in a way of life that works in all circumstances, yet always recognizing the need for searching and finding oneself, is one to whom many a groper may turn for help and guidance, feeling that there will be found tolerance for every struggling idea, all confused thought, all anxious doubt. The tolerant person is a poised adult, full of compassion and understanding for those who are still struggling for maturity of mind and thought.

— *The Nursing Journal of India*

## Incompatible Blood

A conscious patient who receives incompatible blood may show subjective signs and symptoms almost immediately, or the reaction may be delayed and the initial manifestations develop several hours after the completion of the transfusion. When incompatible blood is given to a patient under general anesthesia, however, there are no signs and symptoms to indicate what has happened unless by chance one should examine the urine and discover it to contain precipitated hemoglobin. Usually, in a conscious patient, 10 cc. of incompatible blood will cause a reaction and this is the basis for the "biologic" test (that is, carefully observing the patient during the administration of the first 50 to 100 cc. of blood). The earliest complaints registered by the person receiving incompatible blood are generalized tingling sensations, discomfort, anxiety, fullness of the head, precordial pressure, and a sense of constriction in the chest or difficulty in breathing. The next most characteristic features are pain in the lumbar and chest regions and a chill which is generally followed by a high fever. In addition, signs of shock become evident, such as rapid pulse, cyanosis, nausea and vomiting, and a fall in blood pressure.

— Dr. M. J. Nicholson

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